Washington State
Department of Social and Health Services

Encounter Data Transaction Guide

Version 3.0

JULY 2006

THIS IS NOT A STAND ALONE GUIDE
IT MUST BE USED IN CONJUNCTION WITH:

- **THE 837 HEALTHCARE CLAIM PROFESSIONAL AND INSTITUTIONAL IMPLEMENTATION GUIDES (IG)**
  - **To purchase the IGs contact the Washington Publishing Company at www.wpc-edi.com or call 1-800-972-4334.**

- **THE ACS EDI GATEWAY, INC. X12N 837 HEALTHCARE CLAIM (VERSION 4010A) Professional, Institutional and Dental – Companion Guide**
  - **The ACS EDI Gateway COMPANION GUIDE maybe downloaded from: http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/Companion_Guides/companion_guides.html**

- **THE NCPDP TELECOMMUNICATION STANDARD 5.1 WITH NCPDP BATCH TRANSACTION STANDARD 1.1**
  - **Obtain the Standard from the National Council for Prescription Drug Programs at http://www.ncpdp.org/ , call (480) 477-1000, or Fax your request to (480) 767-1042.**

Document Change Control Table

Author of Change	Page	Change	Reason	Date
MAA/DPS/ISD	All	Version 1.01	Creation of document	09/20/2004
MAA/DPS/DAIS	1-5, 7-9, A-1 and A-2, Mapping Documents, B-2 (see Changes to ED Transaction Guide)	Version 1.02	Update of document and Mapping Documents	03/14/2005
DSHS/DPS/DAIS	All	Version 2.0	Update of document after testing	10/25/05
DSHS/DPS/DAIS	All	Version 3.0	Update of document for new contract year	07/13/2006

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INTRODUCTION

DSHS determined a need to use a standard format for Encounter Data reporting from contracted Managed Care Organizations (MCO). DSHS created this Encounter Data Transaction Guide to assist the MCOs in producing and reporting managed care encounter data in the ANSI ASC X12N 837 Professional and Institutional standard format and the National Council for Prescription Drug Programs (NCPDP) Batch 1.1 format.

MCOs must submit encounter data for services provided to DSHS clients using the National Electronic Data Interchange (EDI) X12N 837P and 837I format. In addition, the NCPDP Batch 1.1 format is required for retail pharmacy drug encounters.

This guide must be used in conjunction with the following documents:

- 837 Healthcare Claim Professional And Institutional Implementation Guides (IG)
  - To purchase the IGs call the Washington Publishing Company at 1-800-972-4334 or contact them through this website www.wpc-edi.com.

- ACS EDI Gateway, Inc. X12N 837 Healthcare Claim (Version 4010A) Professional, Institutional and Dental – Companion Guide
  - Download the ACS EDI Gateway COMPANION GUIDE from: http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/Companion_Guides/companion_guides.html

- NCPDP Telecommunication Standard 5.1 with NCPDP Batch Transaction Standard 1.1. Obtain the Standard from the National Council for Prescription Drug Programs at http://www.ncpdp.org/, call (480) 477-1000, or Fax your request to (480) 767-1042.

Additional DSHS specific requirements for encounter data reporting are included as attachments to this guide.

- ATTACHMENT A:
  - A.1 - 837P Mapping Document for ED Final-V5 Updated 10/25/05
  - A.2 - 837I Mapping Document for ED Final-V5 Updated 10/25/05

- ATTACHMENT B:
  - NCPDP Batch 1.1 Retail Pharmacy Mapping Document

- ATTACHMENT C:
  - DSHS current edits for Encounter Data Processing

- ATTACHMENT D:
  - Electronic Record Transaction (ERT) Layout (ASCII format)
  - Sample 837 Encounter Error Summary Report (EESR)
  - Sample NCPDP Encounter Error Summary Report (EESR)

- ATTACHMENT E:
  - Sample Letter - Certification of Data

DEFINITIONS

ATTENDING PROVIDER: The 7-digit Medicaid ID number assigned by DSHS to the individual provider while the client was inpatient, identifies the primary healthcare provider who attended the client/member during an inpatient hospital stay. This Provider must be identified in 837I, Loop 2310A, REF02 Segment.

BILLING PROVIDER: For Encounter Data reporting, the Billing Provider identified in Loop 2010AA, REF02 segment is the MCO's 7-digit Medicaid ID number assigned by DSHS. This is the primary identifier to distinguish HO, BH+, GAU, WMIP Lines of business (i.e. 7500416, 7500952, 7502453 etc.).

COMPANION GUIDE: ACS EDI-Gateway developed the 837 Companion Guide (CG) for use in conjunction with the Implementation Guide (IG) by all Washington State Trading Partners. The 837 CG includes Washington State specific X12N 837 transaction requirements. This CG is available to download from: http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/Companion_Guides/companion_guides.html

ENCOUNTER: DSHS defines an encounter as a single medical service or a period of examination or treatment provided to a managed care enrollee. DSHS requires MCOs to report all paid claims for health care services delivered to managed care enrollees as encounter data transactions.

ENCOUNTER DATA TRANSACTION (EDT): MCO creates electronic EDT files from the MCO's claims payment system in the X12N 837 format for medical services and the NCPDP 1.1 Batch format for pharmaceutical services. The EDT is then transmitted to DSHS for processing.

ENCOUNTER RESULTS TRANSACTION (ERT): The Medicaid Management Information System (MMIS) creates this electronic file from translating, processing and formatting the EDT to resemble the MMIS adjudicated claim. MMIS returns the electronic ERT file to the MCO with informational flags for the MCOs to identify accepted/rejected encounters.

"GAP" FILLING: Default coding to pass EDI edits. If the MCO cannot obtain and/or does not maintain X12N REQUIRED information, DSHS allows filling these required fields with values consistent to pass EDI syntax. If the field requires specific information from a list in the IG use the most appropriate value for the situation. See Attachment A – Encounter Data Transaction Crosswalks for DSHS required fields.

IMPLEMENTATION GUIDE (IG): Instructions for developing the X12N 837 Health Care Claim/Encounter transaction sets. The Implementation Guides are available from the Washington Publishing Company at www.wpc-edi.com/hipaa/HIPAA_40.asp.

PAY-TO-PROVIDER: For Encounter Data reporting, the Pay-to-Provider in Loop 2010AB, REF02 Segment is the DSHS assigned 7-digit Medicaid ID number of the healthcare provider that was paid by the MCO. This could be a medical group, clinic, hospital, other institution, or the individual provider who rendered the service.

REFERRING PROVIDER: Identifies the individual provider who referred the client or prescribed Ancillary services/items such as Lab, Radiology and Durable Medical Equipment (DME). Report this provider in Loop 2310A, REF02 Segment using the 7-digit Medicaid ID number assigned by DSHS to the referring provider.

RENDERING PROVIDER: Identifies the individual provider who provided the health care service to the client/member. The Rendering Provider was previously known as the Performing Provider. Rendering Providers must be identified in 837P, Loop 2310B, REF02 Segment by the 7-digit Medicaid ID number assigned by DSHS to the individual provider.

TRADING PARTNER AGREEMENT (TPA): Any entity sending electronic claims/encounters to DSHS through ACS EDI-Gateway for processing must enroll as a Trading Partner. Upon enrollment, ACS assigns a Trading Partner ID also known as the MCO's Submitter ID.

GENERAL INFORMATION

VALID PROVIDER IDENTIFIERS: Use the active 7-digit Medicaid Provider ID numbers assigned to all providers who have signed Core Provider Agreements with DSHS to provide healthcare services to Medicaid fee-for-service clients. Until DSHS implements the National Provider Identification (NPI), the X12N 837 format requires the use of the DSHS assigned 7-digit Medicaid Provider Number with the "1D" qualifier in the REF01/02 Segments. Alternate Provider IDs are not acceptable for use with the X12N 837 format.

FINDING PROVIDER IDENTIFIERS: Each week on Monday, DSHS updates and uploads the "Master Provider List" to the Valicert Secure File Transfer (SFT) website. This list includes Medicaid ID numbers for all participating Medicaid providers.

- DSHS automatically notifies the MCO SFT users of this posting by Email.
  - ✓ DSHS authorized SFT users may download this file.
  - ✓ The Field Layout table below lists the structure, layout and additional coding used in the Master Provider List:

FIELD LAYOUT FOR HRSA PROVIDER LISTING

Field Name	Type	Length
Prov_ID	char	10
Name	char	32
Status	char	7
SortName	char	32
Address1	char	27
Address2	char	27
City	char	19
State	char	6
Zip	char	10
County	char	7
TaxID	char	12
TaxCode	char	8
OutOfStCode	char	10
ProvType	char	9
ProvTypeDescription	char	62
LicenseNo	char	9
SSN	char	10
NABP_No	char	11
Spec_Code	char	10
Phone	char	11

  - ✓ You may also find a Medicaid Provider ID number on the Provider Number Reference (PNR) website: http://pnrmaa.dshs.wa.gov .

NON-PARTICIPATING PROVIDER ID: Until the NPI is implemented, MCOs may use the DSHS assigned Non-participating Provider ID "8999070" as the 7-digit Medicaid Provider ID.

This ID number may be used ONLY when the Pay-To, Rendering or Attending provider:

- Does not participate as a Washington Medicaid provider **AND**
- DSHS has not assigned an active Medicaid ID number for the provider.

DSHS will:

- Monitor the use of the Non-participating Medicaid Provider ID each quarter for over-utilization; and will
- Notify the MCO when the number is used more than 25% of the time during an encounter reporting quarter.

ELECTRONIC SUBMISSIONS: Professional, Institutional and Pharmacy encounter claims processed by the MCOs must be reported to DSHS as Encounter Data Transactions (EDT) using the standard X12N 837P, 837I, and NCPDP 1.1 Batch formats.

To submit electronic EDT all MCOs must have a Trading Partner Agreement with a valid Submitter ID assigned by ACS EDI-Gateway, Inc. To obtain a valid Submitter ID and find additional enrollment information check the ACS EDI-Gateway website at: http://www.acs-gcro.com/Medicaid_Accounts/Washington_State_Medicaid/Enrollment/enrollment.html, or call ACS EDI Gateway technical support at 1-800-833-2051.

SUBMISSION FREQUENCY: MCOs must submit EDT at least quarterly with complete data information due no later than the dates listed in the Production Schedule For 2006-2007 *(Refer to table in this section below).*

Room is built into the schedule to give each MCO time to correct and resubmit any files rejected by EDI. It also allows DSHS to stagger and process the receipt of the numerous encounter data file submissions with its vendors. Depending on the business needs, MCOs may submit EDT more frequently when *prearranged* with HRSA.

Resubmitting Corrected Encounters:

- Correct and resubmit rejected encounter claims flagged on the ERT with the next scheduled submission.
- To correct and resubmit rejected Pharmacy encounter claims flagged on the ERT use the B3 = Rebill Indicator in Field 103-A3 *(see Attachment B, NCPDP Retail Pharmacy Mapping Document).* Because there is no allowance in the NCPDP format to report a previous ICN, the HRSA Encounter Process will search the history and enter the previous ICN for you.

NOTE

Please transmit your EDT files between the hours of 6:00 AM – 6:00 PM PST Monday thru Friday.

Your transmissions cannot exceed 100,000 claims per four hour period beginning at 6 AM.

For example, 20 files containing 5,000 claims each can be submitted after 6:00 AM, additional files could then be transmitted after 10:00 AM.

Listed below is the timeframe that files could be submitted, limited to 100,000 claims each, on your scheduled dates.

6:00 AM – 10:00 AM
10:00 AM – 2:00 PM
2:00 PM – 6:00 PM

If an MCO does not exceed 100,000 claims per quarter, then submit all of your files any time between 6:00 AM and 6:00 PM on your scheduled date(s) listed in the Production Schedule for 2006-2007.

837 I & P MEDICAL AND NCPDP PHARMACY PRODUCTION SCHEDULE FOR 2006-2007

MCO	2006-Q2	EDI ERROR CORRECTIONS RESUBMITS	2006-Q3	EDI ERROR CORRECTIONS RESUBMITS
ASURIS	September 11 - 12	September 25	December 4 - 5	December 18
REGENCE	September 11 - 12	September 25	December 4 - 5	December 18
MOLINA	September 13 - 14	September 26	December 6 - 7	December 19
CHPW	September 18 - 19	September 27	December 11 - 12	December 20
CUP	September 20 - 22	September 28 - 29	December 13 - 15	December 21 - 22
EVERCARE	September 20 - 22	September 28 - 29	December 13 - 15	December 21 - 22
GROUP HEALTH	September 20 - 22	September 28 - 29	December 13 - 15	December 21 - 22
KAISER	September 20 - 22	September 28 - 29	December 13 - 15	December 21 - 22
	Contract Due Date October 1, 2006		**Contract Due Date January 2, 2007**	
MCO	**2006-Q4**	**EDI ERROR CORRECTIONS RESUBMITS**	**2007-Q1**	**EDI ERROR CORRECTIONS RESUBMITS**
ASURIS	March 12 - 13	March 26	June 11 - 12	June 25
REGENCE	March 12 - 13	March 26	June 11 - 12	June 25
MOLINA	March 14 - 15	March 27	June 13 - 14	June 26
CHPW	March 19 - 20	March 28	June 18 - 19	June 27
CUP	March 21 - 23	March 29 - 30	June 20 - 21	June 27 - 28
EVERCARE	March 21 - 23	March 29 - 30	June 20 - 21	June 27 - 28
GROUP HEALTH	March 21 - 23	March 29 - 30	June 20 - 21	June 27 - 28
KAISER	March 21 - 23	March 29 - 30	June 20 - 21	June 27 - 28
	Contract Due Date April 1, 2007		**Contract Due Date July 1, 2006**	

ENCOUNTER DATA CERTIFICATION: In accordance with 42 CFR 438.606 and Section 12.9 of the 2006-2007 HO/SCHIP contract MCOs must certify data accuracy and completeness concurrently with each file submission. Each time the MCO submits encounter data files:

1. Send a signed original letter of certification to:

   Peggy Wilson, Office Chief
   Department of Social and Health Services
   Division of Program Support
   Office of Managed Care
   P.O. Box 45530, Olympia, WA 98504-5530

2. Include the following information in each Certification Letter (See Attachment E for a *Sample Letter of Certification)*:

   - Date the EDT batch files are transmitted to DSHS;
   - Name of each file submitted; and
   - Number of encounter claims in each EDT batch file.

3. Highlight the text in each FILE UPLOAD RESPONSE. Copy and paste directly into your email or a Word Document and send to Encounterdata@dshs.wa.gov each time EDT batch files are transmitted. *See "File Preparation" for additional information.*

DSHS VALIDATION PROCESS: After the X12N 837 EDT files and NCPDP 1.1 Batch Encounter files are accepted, the DSHS Encounter Data Program will:

- Process and translate the encounter transactions into MMIS encounter claims.
- Edit the transactions for content against DSHS client eligibility and provider files for valid Medicaid ID numbers as well as valid standard transaction codes sets;
  - ✓ Current Procedural Terminology (CPT).
  - ✓ Standard Edition International Classification of Diseases (ICD.9.CM)
  - ✓ Health Care Financing Administration Comprehensive Procedure Coding System (HCPCS).
  - ✓ Current Dental Terminology (CDT).
  - ✓ National Drug Code (NDC).
- Create an ASCII formatted Electronic Results Transaction (ERT) for the MCO with an Encounter Error Summary Report (EESR) (*See Attachment D*);
  - ✓ The ERT identifies encounters accepted and/or rejected by the MMIS Encounter Data Edit Program and includes both the MCOs Patient Account Number/Medical Record Number and the MMIS 17-digit Internal Control Number (ICN). Encounter ICNs begin with the number "9".
  - ✓ Rejected encounter/claims flagged on the ERT should be corrected and resubmitted for "replacement" processing by the MCO in the next scheduled transmission.

- ✓ Some flags are set to provide the MCO "information only" regarding the encounter/claim transactions. These do not require correction.

  NOTE: *Attachment C* includes the MMIS Encounter Data Program edit flags Field Names and Descriptions.

- Save and transmit the processed EDT files to the DSHS data warehouse Decision Support System (DSS).

DSHS will review encounter data submissions on a quarterly basis after the data is uploaded to the DSS. MCOs will be notified of review findings and if necessary asked to clarify anomalies. Emphasis for this review and validation process includes, but is not limited to:

- Timeliness of the data submissions from the MCO.
- Use of "8999070" non-participating Medicaid ID more than 25% of the time.
- Analyses and reports to provide feedback to the MCOs regarding the quality of data submitted.

ENCOUNTER REPORTING

MEDICAL PROFESSIONAL AND INSTITUTIONAL DATA

PRODUCTION: DSHS requires medical encounter production processing in the X12N 837 format. For EDT follow the Schedule for 2006-2007 located in the "Submission Frequency" section, unless prearranged with HRSA. This schedule is necessary for accurate coordination of the encounter processing.

DSHS strongly recommends integrity testing **prior** to uploading your files. This will reduce the number of rejected EDT. Specific information for EDIFECS is available in the ACS Companion Guide for 837 transactions.

ACS returns a 997 Functional Acknowledgement transaction for each file uploaded. It is important to:

- Review each 997 transaction;
- Correct all errors noted in Rejected and Partially Rejected files;
- Resubmit corrected files according to the schedule for 2006-2007 located in the "Submission Frequency section.

NOTE: *Verify the number of accepted file submissions on the letter of certification to the number of accepted 997 Functional Acknowledgement transactions returned.*

FILE SIZE: The DSHS web portal, WAMedWeb, is capable of handling large files up to 100 MB as long as each ST/SE segment within the file does not contain more than 5000 claims. You can choose to combine several ST/SE segments of 5000 claims each into one large file and upload the file on WAMedWeb as long as the single file does not exceed 100 MB.

For Example: If you have 25,000 claims to send, you can:

1. Separate the claims into 5 ST/SE segments and upload 5 separate files on WAMedWeb; OR

2. Place all 5 ST/SE segments into one file (must be less than 100MB) and upload only one file on WAMedWeb.

Choose One - DSHS recommends Option 1, based on the testing results. A 997 acknowledgement transaction is created for each file uploaded to the WAMedWeb. If you choose Option 2, and roll the ST/SE segments of 5000 claims into one file, you will get only one 997 and either:

- All or part of your 25,000 claims are perfect and accepted or partially rejected; OR
- The DSHS rejects the entire 25,000 claims.

Because this is a large file, finding the EDI errors can be time consuming. Most MCOs find it much easier to separate the files and send 100+ files with 5000 claims each rather than to send 10 files with 50,000 claims.

FILE PREPARATION: Separate files by 837I and 837P type of encounters. All X12N 837 production files must have the appropriate identifiers in the header ISA and REF segments *(Refer to the mapping documents in Attachments A and B of this Guide):*

- Be Sure the Header segment "BHT06" is coded "RP" = Encounter.
- Program the following Header Segments for PRODUCTION:
  1. Header ISA15 to ''P' and
  2. Header REF02 to '**00410X098A1'** (837P); or '**004010X096A1'** (837I)

Name Each File: For DSHS tracking purposes, name each 837 file. See example below:

- Use the MCO standard abbreviation (ANH/CHPW/CUP/EVCR/GHC/KHP/MHC/RBS);
- Add "837PROD";
- Specify the Encounter Type and the number of claims in the file (**I**#### or **P**####);
- Include Date file is first submitted to DSHS (YYYYMMDD);
- For multiple files of the same type and/or size, add an alpha or numeric character.
  - ✓ **For Example**: RBS_837PROD_P5000_20060731A
- Resubmitted files should retain the original file name and:
  - ✓ Add R1, R2…at the end of the file name.

Transmit your 837 Production files to DSHS using the WAMedWeb production website: https://wamedweb.acs-inc.com/wa/general/home.do . DSHS acknowledges receipt of each submission with a File Upload Response.

Combine the copied text from your 837 File Upload Responses into a single document - Highlight the text in each file UPLOAD RESPONSE, copy and paste into a Word Document or directly into your email – DO NOT send **.jpg files or copies of the web page.**

EXAMPLE of File Upload Response:

The following file has been successfully Uploaded:	
File Name	CUP_837PROD_P7367_20060731R1
File Size	8067586 (bytes)
Submitter ID	8021412
Date/Time	07/31/2006

Email copies of the **text** from your File Upload Responses to the Encounterdata@dshs.wa.gov each time 837 EDT batch files are transmitted to DSHS.

Retrieve the 997 from the WAMedWeb site. DSHS posts an electronic X12N 997 (Functional Acknowledgement) transaction to acknowledge receipt of your files. *Please see the 837 IG for additional information about the response coding.*

- The 997acknowledges whether your files are accepted, rejected or partially rejected.
- A 997 is generated when each X12N 837 file passes the header and trailer check and the EDI formatting edits.
- If you do not receive a 997 for each 837 file submitted please check the headers and trailers to ensure correct coding.
- Review each 997 transaction;
- Correct all errors noted in Rejected and Partially Rejected files;
- Resubmit corrected files according to the schedule table for 2006-2007 located in the "Submission Frequency" section.

Compare the 997 name. DSHS EDI assigns a new name to each file; that name that is shown on the title of the file names for each 997. For effective claim count balancing, DSHS asks each MCO to note the 997 EDI File Names that belong with each Original File Name. Use of both file names will enable you to identify files/claims that were not processed when comparing the ERT to each file you transmitted.

> **NOTE***: Remember to review the 997 information with your data files. Correct and resubmit files rejected by the EDI edits, following the established submission procedures and scheduled timeline listed above.*

TESTING: DSHS will accept test encounter data from the MCOs on a case-by-case basis only. Send notification of your intent to test to Encounterdata@dshs.wa.gov. We'll call you to schedule/coordinate the test. If necessary, after your test data is processed, DSHS will contact and meet with you to review the findings.

RETAIL PHARMACY DATA

RETAIL PHARMACY ENCOUNTERS: DSHS requires the standard NCPDP 1.1 batch format for submission of your Retail Pharmacy encounter claims.

PRODUCTION: To send your NCPDP 1.1 retail pharmacy encounter data batch files:

Create encounter pharmacy files in the NCPDP 1.1 Batch Claims format: (*Refer to Attachment B in this guide for the NCPDP 1.1 Batch Format Mapping Document.)*

- Set Header Field 702 for P = PRODUCTION; and
- Detail Data Record Field 104-A4 to PRODDRWAPROD = PRODUCTION CLAIMS

ZIP or compress each file before transmitting.

- Place multiple batches into one zip archive so you are uploading only 1 file as long as the batches are identifiable (each has a different number).
- Name each internal batch file something meaningful to you.

Name each Zipped / Compressed batch file; The file name placed on the ACS PBM Web site must be CLAIMIN.zip (Case-Sensitive). On the ACS PBM FTP site, the file name needs to be the same fixed name within your directory.

Upload your Pharmacy encounter files to the ACS FTP Batch System at the following URL: https://www.pbmftp.com/ into the PRODUCTION SUB-DIRECTORY. Please refer to your "Pharmacy Batch Encounter Claims for Managed Care Organizations" instruction guide for more specific information. *Logon user IDs and passwords are case sensitive*.

Email upload notifications to the DSHS Encounter Data Group.

- Send the notification to:
  - ✓ michael.pedersen@acs-inc.com AND
  - ✓ Encounterdata@dshs.wa.gov
- Always cc: the following people in your email:
  - ✓ randy.stamp@acs-inc.com
  - ✓ gia.elsevier@acs-inc.com

997s are not generated for pharmacy encounters. After processing your pharmacy data through the DSHS Encounter Data program, we will:

- ✓ Upload a copy of your ERT and Encounter Summary Reports to the HRSA Valicert SFT site; and
- ✓ Send email notification that the reports are ready to download.

Correct and resubmit rejected Pharmacy encounter claims flagged on the ERT using the B3 = Rebill Indicator in Field 103-A3. The DSHS Pharmacy Encounter Process will enter the Original/Previous ICN.

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
Header	**ISA**	**Interchange Control Header**					**ISA must have fixed length data**
Header	ISA01	Authorization Information Qualifier	ID2	"**00**" = No Authorization Information Present	Literal	Required	
Header	ISA02	Authorization Data Identification	AN10	[**ten spaces**] - No Meaningful Information	Literal	Required	
Header	ISA03	Security Information Qualifier	ID2	"**00**" = No Security Information Present	Literal	Required	
Header	ISA04	Security Information	AN10	[**ten spaces**] - No Meaningful Information	Literal	Required	
Header	ISA05	Interchange ID Qualifier	ID2	<Configured Sender's ID type> Use "**ZZ**"	Configure	Required	See 837P IG Appendix B for valid values
Header	ISA06	Interchange Sender ID	AN15	<Configured Sender's ID> Use your 7-digit Trading Partner ID "**80XXXXX**"	Configure	Required	
Header	ISA07	Interchange ID Qualifier	ID2	<Configured Receiver's ID type> Use "**ZZ**"	Configure	Required	See 837P IG Appendix B for valid values
Header	ISA08	Interchange Receiver ID	AN15	"**100000**" followed by "spaces"	Literal	Required	
Header	ISA09	Interchange Date	DT6	<Derive current date>	Derive	Required	YYMMDD
Header	ISA10	Interchange Time	TM4	<Derive current time>	Derive	Required	HHMM
Header	ISA11	Interchange Control Standards Identifier	ID1	"**U**" = U.S. EDI	Literal	Required	
Header	ISA12	Interchange Control Version Number	ID5	"**00401**"	Literal	Required	
Header	ISA13	Interchange Control Number	N9	<Derive unique ID for all ISAs from this sender: timestamp precise to hundredths of a second>	Derive	Required	

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
Header	ISA14	Acknowledgement Request	ID1	<Default to: "**0**" = No Ack Requested>; "**1**" = Interchange Ack Requested	Use Default	Required	
Header	ISA15	Usage Indicator	ID1	<Configured usage> **P** = Production **T** = Test Data	Configure	Required	
Header	ISA16	Component Element Separator	1	" **:** " = Component Delimiter	Literal	Required	
Header	**GS**	**Functional Group Header**					**One functional group for each set of same transactions**
Header	GS01	Functional Identifier Code	ID2	"**HC**"-Health Care Claim (837)	Literal	Required	Depends on transaction
Header	GS02	Application Sender's Code	AN15	<Configure Sender's sub-division> Use your 7-digit Trading Partner ID number "**80XXXXX**"	Configure	Required	<ID for sub-div of ISA06>
Header	GS03	Application Receiver's Code	AN15	"**77045**"	Literal	Required	<ID for sub-div of ISA08>
Header	GS04	Date	DT8	<Derive current date>	Derive	Required	CCYYMMDD
Header	GS05	Time	TM8	<Derive current time>	Derive	Required	HHMM(SSDD)
Header	GS06	Group Control Number	N9	<Default to unique ID for each GS from this sender: timestamp precise to hundredths of a second>	Default	Required	Batch Number
Header	GS07	Responsible Agency Code	ID2	"**X**" - ASC X12	Literal	Required	
Header	GS08	Version/Release/ Industry Identifier Code	AN12	"**004010X098A1**"	Literal	Required	Use addenda version "004010X098A1"

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
Header	**ST**	**Transaction Set Header**					
Header	ST01	Transaction Set Identifier Code	ID3	"**837**" - Health Care Claim	Literal	Required	
Header	ST02	Transaction Set Control Number	AN9	<Derive submitter sequence # from 1 by 1 for each transaction>	Derive	Required	
Header	**BHT**	**Beginning of Hierarchical Transaction**					
Header	BHT01	Hierarchical Structure Code	ID4	"**0019**" = Info Source, Subscriber, Dependent	Literal	Required	
Header	BHT02	Transaction Set Purpose Code	ID2	"**00**" = Original "**18**" = Reissue	Derive	Required	Electronic Transmission Status - **Original** = Never Sent to Receiver; **Reissue** = Transmission Disrupted, Sending Batch Again.
Header	BHT03	Originator Application Transaction Identifier	AN30	<Derive unique transmission ID from originator's system: timestamp precise to hundredths of a second>	Derive	Required	
Header	BHT04	Transaction Set Creation Date	DT8	<Default to current date if no claim submitted date>	Default	Required	CCYYMMDD
Header	BHT05	Transaction Set Creation Time	TM8	<Default to "**23595999**"- midnight>	Default	Required	HHMMSSDD
Header	BHT06	Claim or Encounter Identifier	ID2	"**RP**" = Encounter	Required	Required	**Always** USE "RP"
Header	**REF**	**Transmission Type Identification**					
Header	REF01	Reference Identification Qualifier	ID3	"**87**" = Functional Category	Literal	Required	

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
Header	REF02	Transmission Type Code	AN30	"**004010X098A1**" = Production; "**004010X098DA1**" = Test	Derive	Required	
1000A	**NM1**	**Submitter Name**					**Submitter Loop is information about the MCO**
1000A	NM101	Entity Identifier Code	ID3	"**41**" = Submitter	Required	Required	
1000A	NM102	Entity Type Qualifier	ID1	<Configure MCO data> "**2**" = Non-person	Required	Required	**Always** Non-Person
1000A	NM103	Submitter Last or Organization Name	AN35	<Configure MCO data>	Required	Required	**Use MCO's Abbreviated Name** (ANH; CHPW; CUP; EVCR; GHC; MHC; RBS)
1000A	NM104	Submitter First Name	AN25	<Configure MCO data>	Not Required	Not Required	
1000A	NM105	Submitter Middle Name	AN25	<Configure MCO data>	Not Required	Not Required	
1000A	NM108	Identification Code Qualifier	ID2	"**46**" = ETIN	Required	Required	Electronic Transmission Identification Number
1000A	NM109	Submitter Identifier	AN80	MCO Submitter ID number - "**80xxxxx**"	Required	Required	Same as the ACS EDI Gateway Trading Partner ID Number
1000A	**PER**	**Submitter EDI Contact Information**					**MCO Contact information**
1000A	PER01	Contact Function Code	ID2	Literal "**IC**"	Required	Required	Information Contact
1000A	PER02	Submitter Contact name	AN60	Name of Person to contact at the MCO regarding information in this submission	Required	Required	
1000A	PER03	Communication Number Qualifier	ID2	**EM** = Email Address; or **TE** = Telephone Number	Required	Required	
1000A	PER04	Communication Number	AN80		Required	Required	

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
1000B	**NM1**	**Receiver Name**					**The Receiver Loop identifies DSHS/HRSA (MAA)**
1000B	NM101	Entity Identifier Code	ID3	"**40**" = Receiver	Literal	Required	
1000B	NM102	Entity Type Qualifier	ID1	"**2**" = Non-Person	Literal	Required	
1000B	NM103	Receiver Name	AN35	"**WA DSHS MAA**"	Literal	Required	MAA = HRSA
1000B	NM108	Identification Code Qualifier	ID2	"**46**" = ETIN	Literal	Required	Electronic Transmission Identification Number
1000B	NM109	Receiver Primary Identifier	AN80	"**77045**"	Literal	Required	
2000A	**HL**	**Billing Provider Hierarchical Level**					
2000A	HL01	Hierarchical ID Number	AN12	<increment from 1 by 1 for each HL segment in transaction>	Derive	Required	Increment from 1 by 1 for each HL segment in transaction
2000A	HL03	Hierarchical Level Code	ID2	"**20**" = Information Source	Literal	Required	
2000A	HL04	Hierarchical Child Code	ID1	"**1**" = Child HL Follows	Literal	Required	
2010AA	**NM1**	**Billing Provider Name**					**For Encounter Data Reporting the Billing Provider Loop will be used to identify the MCO and the Line of Business (HO, BH+, GAU, WMIP)**
2010AA	NM101	Entity Identifier Code	ID3	"**85**" = Billing Provider	Literal	Required	For Encounter Data Reporting the Billing Provider always = MCO
2010AA	NM102	Entity Type Qualifier	ID1	"1" = Person; "**2**" = Non-Person	Required	Required	**Always** 2 = Non-Person

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2010AA	NM103	Billing Provider Last or Organizational Name	AN35	>Organization Name <Configure MCO data	Required	Required	For Encounter Data reporting use MCO's Abbreviated Name **(GHC; MHC; CHPW; RBS; ANH; CUPP; KHPP etc)**
2010AA	NM108	Identification Code Qualifier	ID2	"**24**"= Employer ID; or "34"=SSN; or "XX" = NPI (future)	Required	Required	**Always** "24"
2010AA	NM109	Billing Provider Identifier	AN80	Standard Tax-ID for billing provider or future NPI	Required	Required	**Always** use the Tax ID or NPI of the MCO.
2010AA	**N3**	**Billing Provider Address**					
2010AA	N301	Billing Provider Address Line	AN55		Required	Required	**Always** the Address of the MCO reporting the data.
2010AA	N302	Billing Provider Address Line	AN55		Not required	Not Required	
2010AA	**N4**	**Billing Provider City/State/ZIP Code**					
2010AA	N401	Billing Provider City Name	AN30		Required	Required	**Always** the City of the MCO reporting the data.
2010AA	N402	Billing Provider State or Province Code	ID2		Required	Required	
2010AA	N403	Billing Provider Postal Zone or ZIP Code	ID15		Required	Required	
2010AA	**REF**	**Billing Provider Secondary Identification**					
2010AA	REF01	Reference Identification Qualifier	ID3	"**1D**" = Medicaid Provider ID	Required	Required	

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2010AA	REF02	Billing Provider Additional Identifier	AN30	This must be the MCO's active 7-digit Medicaid Provider ID number "**75XXXXX**"	Required	Required	MCO Provider Medicaid Number for DSHS- the Medicaid ID number for the specific Line-of-Business (HO or BH+).
2010AB	**NM1**	**Pay-To-Provider Name**					**For Encounter Data - Always use the information of the healthcare provider who received PAYMENT for the services from the MCO**
2010AB	NM101	Entity Identifier Code	ID3	"**87**" = Pay-To-Provider	Literal	Required	**Always** "87"
2010AB	NM102	Entity Type Qualifier	ID1	"**1**" = Person; or "**2**" = Non-Person	Required	Required	
2010AB	NM103	Pay-To-Provider Last or Organizational Name	AN35	>Last Name / Org. Name <Configure MCO data	Required	Required	The name of the individual or organization who received payment from the MCO for services
2010AB	NM104	Pay-To-Provider First Name	AN25	Individual's First Name	Required if a person		
2010AB	NM105	Pay-To-Provider Middle Name	AN25		Optional	Optional	
2010AB	NM107	Pay-To-Provider Name Suffix	AN10		Optional	Optional	
2010AB	NM108	Identification Code Qualifier	ID2	"**24**" = Employer ID or "**34**" = SSN or "**XX**" = NPI (future)	Required	Required	
2010AB	NM109	Pay-To-Provider Identifier	AN80	Standard Tax-ID or NPI for Pay-To-Provider	Required	Required	
2010AB	**N3**	**Pay-To-Provider Address**					
2010AB	N301	Pay-To-Provider Address Line	AN55		Required	Required	

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2010AB	N302	Pay-To-Provider Address Line	AN55		Not Required	Not Required	
2010AB	**N4**	**Pay-To-Provider City/State/ZIP Code**					
2010AB	N401	Pay-To-Provider City Name	AN30		Required	Required	
2010AB	N402	Pay-To-Provider State or Province Code	ID2		Required	Required	
2010AB	N403	Pay-To-Provider Postal Zone or ZIP Code	ID15		Required	Required	
2010AB	**REF**	**Pay-To-Provider Secondary Identification**					
2010AB	REF01	Reference Identification Qualifier	ID3	"**1D**" - Medicaid Provider ID	Required	Not Required	
2010AB	REF02	Pay-To-Provider Additional Identifier	AN30	The 7-digit DSHS Assigned Medicaid ID number for the individual provider who receives payment for the healthcare service.	Required	Not Required	This must be a valid and **active** Medicaid Provider ID number for the date(s) of service. "8999070" default okay up to 25%.
2000B	**HL**	**Subscriber Hierarchical Level**					**Validate sequence #s to ensure correct structure**
2000B	HL01	Hierarchical ID Number	AN12	<increment from 1 by 1 for each HL segment in transaction>	Derive	Required	
2000B	HL02	Hierarchical Parent ID Number	AN12	<HL01 value of parent HL segment>	Derive	Required	Parent HL01 value
2000B	HL03	Hierarchical Level Code	ID2	"**22**" = Subscriber	Literal	Required	
2000B	HL04	Hierarchical Child Code	ID1	"**0**" = no subordinate HL segments	Literal	Required	Patient is **Always** the Subscriber

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2000B	**SBR**	**Subscriber Information**					**The Subscriber is the MCO member receiving the service**
2000B	SBR01	Payer Responsibility Sequence Number code	ID1	"**P**" = Primary	Literal	Required	For Encounter Data reporting **always** use "P"
2000B	SBR02	Individual Relationship Code	ID2	"**18**" = Self	Required if subscriber = patient	Required if subscriber = patient	Use "18"-Self, or nothing
2000B	SBR09	Claim Filing Indicator Code	ID2	"**MC**"-Medicaid	Literal	Required	
2010BA	**NM1**	**Subscriber Name**					
2010BA	NM101	Entity Identifier Code	ID3	"**IL**" = Insured	Literal	Required	
2010BA	NM102	Entity Type Qualifier	ID1	"**1**" = Person	Literal	Required	
2010BA	NM103	Subscriber Last Name	AN35	Subscriber Last Name	Required	Required	
2010BA	NM104	Subscriber First Name	AN25	Subscriber First Name	Required	Required	
2010BA	NM105	Subscriber Middle Name/Initial	AN25	Subscriber Middle Name/Initial	Required if known	Required if known	
2010BA	NM108	Identification Code Qualifier	ID2	"**MI**" = Member ID	Literal	Required if Subscriber = Patient	Patient is **Always** the Subscriber
2010BA	NM109	Subscriber Primary Identifier	AN80	**PIC** (For DSHS - The PIC is always the primary identifier of the subscriber).	Required	Required	Enter the Medicaid assigned Patient Identification Code (PIC) using the Display Format – e.g. John Q Public: **JQ083104PUBLIA**
2010BA	**N3**	**Subscriber Address Information**					
	N301	Subscriber Address Line	AN55	Subscriber Address Line	Required	Required	
	N302	Second line Subscriber Address	AN55	Second line Subscriber Address	Required	Required	
2010BA	**N4**	**Subscriber City/State/Zip Code**					

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
	N401	Subscriber City Name	AN30	Subscriber City Name	Required	Required	
	N402	Subscriber State Code	ID2	Subscriber State Code	Required	Required	
	N403	Subscriber Zip Code	ID15	Subscriber Zip Code	Required	Required	
2010BA	**DMG**	**Subscriber Demographic Information**					
2010BA	DMG01	Date Time Period Format Qualifier	ID3	"**D8**" = CCYYMMDD	Literal	Required	
2010BA	DMG02	Subscriber Birth Date	AN35	Subscriber's Birth date	Required	Required	CCYYMMDD
2010BA	DMG03	Subscriber Gender Code	ID1	"**M**" = Male; "**F**" = Female; "**U**" = Unknown	Required if Subscriber = Patient	Required	
2010BA	**REF**	**Subscriber Secondary Identification**					
2010BA	REF01	Reference Identification Qualifier	ID3	"**SY**"-SSN	Literal	Not Required	
2010BA	REF02	Subscriber Supplemental Identifier	AN30	Subscriber's **SSN**	Required	Not Required	For Encounter Data reporting the Subscriber's SSN is required to help correctly identify the client. Hard code "123456789" if not available.
2010BB	**NM1**	**Payer Name**					**For Encounter Data - HRSA is always the "Payer"**
2010BB	NM101	Entity Identifier Code	ID3	"**PR**" = Payer	Required	Required	
2010BB	NM102	Entity Type Qualifier	ID1	"**2**" = Organization	Required	Required	
2010BB	NM103	Payer Name - Name Last/Org. Name	AN35	**"WA DSHS MAA"**	Required	Required	Washington State Medicaid - HRSA (MAA) is **always** the payer
2010BB	NM108	Identification Code Qualifier	ID2	"**PI**"-Payer's ID	Literal	Required	

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Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2010BB	NM109	Payer Identifier	AN80	**"77045"**	Required	Required	Enter HRSA's Payer Identifier for EDI
2300	**CLM**	**Claim Information**					**This segment applies to the entire claim / Encounter - Recommended Max is 5000**
2300	CLM01	Claim Submitter's Identifier (also known as the Patient Account Number/Patient Control Number)	AN38	Claim Number from the MCO's Claim Payment System	Required	Required	This number will be returned to the MCO on the Encounter Results Transaction (ERT) after HRSA's Encounter Data validation processing.
2300	CLM02	Total Claim Charge Amount	R18	Total Claim Charge Amount	Required	Required	
2300	**CLM05**	**Health Care Service Location Information**					
2300	CLM05-1	Facility Code Value	AN2	Place of Service	Required	Required	See IG for valid values
2300	CLM05-3	Claim Frequency Code	ID1	"**1**"= Original Encounter Record; "**7**" = replace previously edited/rejected Encounter Record	Required	Required	Use "7" when submitting DSHS rejected error corrections and replacing previously submitted Encounter Records.
2300	CLM06	Provider/Supplier Signature Indicator	ID1	"**N**" (Default)	Literal	Required	**Always** use "N" for encounter data reporting
2300	CLM07	Provider Accept Assignment Code	ID1	"**C**" (Default)	Literal	Required	**Always** use "C" for encounter data reporting
2300	CLM08	Benefits Assignment Cert Indicator	ID1	"**Y**" (Default)	Literal	Required	**Always** use "Y" for encounter data reporting
2300	CLM09	Release of Information Code	ID1	"**Y**" (Default)	Literal	Required	**Always** use "Y" for encounter data reporting
2300	CLM10	Patient Signature Source Code	ID1	"**C**" (Default)	Literal	Required	**Always** use "C" for encounter data reporting

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Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2300	**DTP**	**Dates**			**Required only if available AND situation exists**	**Situational**	
2300	DTP01	Date Time Qualifier	ID3	"**435**" = Hospital Admission	Literal	Required if claim is for **Inpatient services** or **ambulance service with Inpatient admission**	ACS-EDI edit is based on facility type code Loop 2300 Segment CLM05-1
2300	DTP02	Date Time Period Format Qualifier	ID3	"**D8**" = CCYYMMDD	Literal	Required if claim is for Inpatient services or ambulance service with Inpatient admission	
2300	DTP03	Related Hospitalization Admission Date	AN35	"**CCYYMMDD**" Hospital Admission Date	Required if claim is for Inpatient services, or Ambulance service with Inpatient admission	Required if claim is for Inpatient services, or Ambulance service with Inpatient admission	Hard Code okay - DO NOT zero fill. Date must be within Statement Dates
2300	DTP01	Date Time Qualifier	ID3	"**096**"- Hospital Discharge	Literal	Required if claim is for Inpatient services on Date of Discharge	ACS-EDI edit is based on facility type code in Loop 2300 Segment CLM05-1

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2300	DTP02	Date Time Period Format Qualifier	ID3	"**D8**" = CCYYMMDD	Literal	Required if claim is for Inpatient services on Date of Discharge	
2300	DTP03	Related Hospitalization Discharge Date	AN35	"**CCYYMMDD**"	Required if claim is for Inpatient services on Date of discharge	Required if claim is for Inpatient services on Date of Discharge	Hard Code okay - DO NOT zero fill. Date must be within Statement Dates
2300	**REF**	**Original Reference Number (ICN/DCN)**					
2300	REF01	Reference Identification Qualifier	ID3	"**F8**" = Original Reference Number	Literal	Required when situation exists	Use ONLY when the Claim Frequency Code in CLM05-3 equals "**7**" when submitting HRSA rejected error corrections and replacing previously submitted Encounter Records.
2300	REF02	Claim Original Reference Number	AN30	Reference the "**Original/Previous**" ICN number assigned by HRSA to the originally submitted Encounter record	Required when the Claim Frequency Code in CLM05-3 = "**7**".	Required	Use ONLY when the Claim Frequency Code in CLM05-3 equals "**7**" when submitting HRSA rejected error corrections and replacing previously submitted Encounter Records.
2300	**NTE**	**Claim Note**					
2300	NTE01	Note Reference Code	ID3	Literal = "**PMT**"	Required if denied SVC line items in claim	Not Required	Use only "PMT"

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Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2300	NTE02	Claim Note Text	AN80	Denied Line Items	Required if denied SVC line items in claim	Not required	Report Denied Line Items here. Use the letter D as your delimiter between 3-digit line numbers, no spaces. (i.e. D###). Use 2400 NTE field for >18 denied lines.
2300	**CR1**	**Ambulance Transport Information**		**Use this segment ONLY if situation applies and information is available**	**Use this segment ONLY if situation applies and information is available**	**Situational**	**If segment is used Follow IG for syntax - information is not edited by HRSA**
2300	**CR2**	**Spinal Manipulation Service Information**		**Use this segment ONLY if situation applies and information is available**	**Use this segment ONLY if situation applies and information is available**	**Situational**	**If segment is used Follow IG for syntax - information is not edited by HRSA**
2300	**CRC**	**Conditions code indicators**		**Use this segment ONLY if situation applies and information is available**	**Use this segment ONLY if situation applies and information is available**	**Situational**	**If segment is used Follow IG for syntax - information is not edited by HRSA**
2300	**HI**	**Health Care Diagnosis Code**					
2300	HI01	Health Care Code Information		**Principal** Diagnosis Code	Required on all Encounter records	Required on all Encounter records	Gather Diagnoses for service lines here
2300	HI01-1	Diagnosis Type Code Qualifier	ID3	"**BK**" = Principal Diagnosis	Literal		

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Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2300	HI01-2	Diagnosis Code	AN30	**Principal** Diagnosis Code	Required	Required	ICD9 code - **Do not use** Diagnosis codes starting with "E" **in this segment**.
2300	**HI02**	**Health Care Code Information**		**Additional Diagnosis Codes**		**Required if needed to report additional Diagnoses**	**Repeat segment up to 8 times**
2300	HI02-1	Diagnosis Type Code Qualifier	ID3	"**BF**" Diagnosis	Literal	Required if used	
2300	HI02-2	Diagnosis Code	AN30	**Other** Diagnosis Code	Required if needed to report additional Diagnoses	Required if needed to report additional Diagnoses	ICD9 code - Use this segment or later segments to report diagnosis codes starting with "E"
2305	**CR7**	**Home Health Care Plan Information**					**If segment is used follow IG for syntax - information is not edited by HRSA**
2305	CR701	Discipline Type Code	ID2	See IG for valid values	Required for Home Health visits	Required for Home Health visits	
2305	CR702	Total Visits Rendered Count	N09		Required for Home Health visits	Required for Home Health visits	
2305	CR703	Certification Period Projected Visit Count	N09		Required for Home Health visits	Required for Home Health visits	
2310A	**NM1**	**Referring Provider Name**					**For claims such as DME, Lab, Radiology or consults that require a Referring Physician**
2310A	NM101	Entity Identifier Code	ID3	"**DN**" = Referring Provider	Literal	Required if claim involves a referral	

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2310A	NM102	Entity Type Qualifier	ID1	"**1**" = Person; "**2**" = Non-Person	Required if claim involves a referral	Required if claim involves a referral	
2310A	NM103	Referring Provider Last or Organization Name	AN35		Required if claim involves a referral	Required if claim involves a referral	
2310A	NM104	Referring Provider First Name	AN25		Required if a person	Required if a person	
2310A	NM105	Referring Provider Middle Name	AN25		optional	Not Required	
2310A	NM107	Referring Provider Name Suffix	AN10		optional	Not Required	
2310A	NM108	Identification Code Qualifier	ID2	"**24**" = Employer ID; or "**34**" = SSN; or "**XX**" = NPI (future)	Required if claim involves a referral	Required if claim involves a referral	
2310A	NM109	Referring Provider Identifier	AN80	EIN, SSN or NPI (future)	Required if claim involves a referral	Required if claim involves a referral	Hard code okay if unknown
2310A	**REF**	**Referring Provider Secondary Identification**					**The Medicaid ID number is the primary identifier of providers**
2310A	REF01	Reference Identification Qualifier	ID3	"**1D**" = Medicaid ID	Literal	Required if claim involves a referral	
2310A	REF02	Referring Provider Secondary Identifier	AN30	The 7-digit DSHS Assigned Medicaid ID number for the individual provider who referred the service.	Required if claim involves a referral	Required if claim involves a referral	This must be a valid and **active** Medicaid Provider ID number for the date(s) of service. "8999070" default okay up to 25%.
2310B	**NM1**	**Rendering Provider Name**					

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Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2310B	NM101	Entity Identifier Code	ID3	"**82**" = Rendering Provider	Literal	Required if Rendering <> Pay-To	
2310B	NM102	Entity Type Qualifier	ID1	"**1**" = Person; "**2**" = Non-Person	Required if Rendering <> pay-to	Required if Rendering <> Pay-To	
2310B	NM103	Rendering Provider Last or Organization Name	AN35		Required if Rendering <> pay-to	Required if Rendering <> Pay-To	
2310B	NM104	Rendering Provider First Name	AN25		Required if a person	Required if a person	
2310B	NM105	Rendering Provider Middle Name	AN25		optional	Not required	
2310B	NM107	Rendering Provider Name Suffix	AN10		optional	Not required	
2310B	NM108	Identification Code Qualifier	ID2	"**24**" = Employer ID; or "**34**" = SSN; or "**XX**" = NPI (future)	Required if rendering <> pay-to	Required if Rendering <> Pay-To	
2310B	NM109	Rendering Provider Identifier	AN80	EIN / SSN, NPI(future)	Required if rendering <> pay-to	Required if Rendering <> Pay-To	Hard code okay if unknown
2310B	**REF**	**Rendering Provider Secondary Identification**					**The Medicaid ID number is the primary identifier of providers**
2310B	REF01	Reference Identification Qualifier	ID3	"**1D**"-Medicaid ID	Literal	Required if Rendering <> Pay-To	
2310B	REF02	Rendering Provider Secondary Identifier	AN30	The 7-digit DSHS Assigned Medicaid ID number for the individual provider who Rendered the service.	Required if rendering <> pay-to	Required if Rendering <> pay-to	This must be a valid and **active** Medicaid Provider ID number for the date(s) of service. "8999070" default okay up to 25%.
2400	**LX**	**Service Line**					

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2400	LX 01	Assign Number	N06	Line Item Number	Required	Required	<Must derive sequential # from 1 by 1 for each service line>
2400	**SV1**	**Professional Service**					
2400	**SV101**	**Composite Medical Procedure Identifier**					
2400	SV101-1	Product or Service ID Qualifier	ID2	"**HC**" = HCPCS / CPT standard codes; "**IV**" = Home Infusion EDI (HEIC) codes.	Required	Required	Use "HC" for most service codes.
2400	SV101-2	Procedure Code	AN48	**Primary** Procedure	Required	Required	Must be HCPCS or CPT **- DO NOT** Use ICD-9-CM Procedure codes here.
2400	SV101-3	Procedure Modifier	AN2	Procedure Code **Modifier**	Required if clarifies proc code	Required if clarifies proc code	Up to 4 different Modifiers allowed for each Procedure Code repeating the SV101-3 segment - SEE IG
2400	SV102	Monetary amount	R18	Line Item Charge Amount	Required	Required	
2400	SV103	Unit or Basis for Measurement Code	ID2	"**UN**" = Unit; "**MJ**" = Minutes; "**F2**" = Drug IU	Required	Required	
2400	SV104	Quantity-Service Unit Count	R15	Units of Service	Required	Required	
2400	SV105	Facility Code Value	AN2	Place of Service	Required if <> claim level (CLM05-1)	Required if <> claim level (CLM05-1)	See Guide for valid Professional Place Of Service values
2400	SV107	Composite Diagnosis Code Pointer	N02		Required if HI segment in Loop 2300 is used		This code points the service to the primary diagnosis at the claim level

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
2400	SV107-1	Diagnosis Code Pointer	N02	Acceptable values are: **1 - 8**	Required	Required	Repeat SV107 for each diagnosis used in Loop 2300 HI segment
2400	SV5	Durable Medical Equipment Service			Required if DME	Required if DME	Follow IG for this segment when reporting DME services
2400	CR5	Home Oxygen Therapy Information			Required for home oxygen therapy	Required for home oxygen therapy	See IG for valid values and required segments if used.
2400	**DTP**	**Date - Service Date**					
2400	DTP01	Date Time Qualifier	ID3	"**472**" = Date of Service	Literal	Required	
2400	DTP02	Date Time Period Format Qualifier	ID3	"**D8**" = for single date of service; OR "**RD8**" = Range of from & to dates	Literal	Required	"D8"-CCYYMMDD; "RD8"-CCYYMMDD-CCYYMMDD
2400	DTP03	Service Date	AN35	From or From - To Date of Service in **CCYYMMDD** format	Required	Required	
2400	**NTE**	**Line Note**					
2400	NTE01	Note Reference Code	ID3	Literal = "**PMT**"	Required if denied SVC line items in claim	Not Required	Use only "PMT"
2400	NTE02	Line Note Text	AN80	Denied Line Items	Required if denied SVC line items in claim	Not Required	Report Denied Line Items here. Use the letter D as your delimiter between 3-digit line numbers, no spaces. (i.e. D###). Use 2400 NTE field for >18 denied lines.
Trailer	**SE**	**Transaction Set Trailer**					
Trailer	SE01	Transaction Segment Count	N10		Derive	Required	Count number of segments in trans

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 Data Content	DSHS Requirement	837 P Implementation Guide (IG) Requirements	Comments
Trailer	SE02	Transaction Set Control Number	AN9		Derive	Required	Same as ST02
Trailer	**GE**	**Functional Group Trailer**					
Trailer	GE01	Number of Transaction Sets Included	N6		Derive	Required	Count number of transactions in group
Trailer	GE02	Group Control Number	N9		Derive	Required	Unique ID for each GS/GE from this sender
Trailer	**IEA**	**Interchange Control Trailer**					
Trailer	IEA01	Number of Included Functional Groups	N5		Derive	Required	
Trailer	IEA02	Interchange Control Number	N9		Derive	Required	Unique ID for each ISA/IEA from this sender

Place of Service Codes for Professional Claims

Listed below are place of service codes and descriptions to be used on professional claims to specify where service(s) were provided.

(CMS update 3/22/2006)

Place of Service Code(s)	Place of Service Name
1	Pharmacy**
3	School
4	Homeless Shelter
5	Indian Health Service Free-standing Facility
6	Indian Health Service Provider-based Facility
7	Tribal 638 Free-standing Facility
8	Tribal 638 Provider-based Facility
9	Prison-Correctional Facility***
11	Office
12	Home
13	Assisted Living Facility
14	Group Home*
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance - Land
42	Ambulance – Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility-Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center

Place of Service Code(s)	Place of Service Name
57	**Non-residential Substance Abuse Treatment Facility**
60	**Mass Immunization Center**
61	**Comprehensive Inpatient Rehabilitation Facility**
62	**Comprehensive Outpatient Rehabilitation Facility**
65	**End-Stage Renal Disease Treatment Facility**
71	**Public Health Clinic**
72	**Rural Health Clinic**
81	**Independent Laboratory**
99	**Other Place of Service**

* Revised, effective April 1, 2004.
** Revised, effective October 1, 2005
*** Revised, effective July 1, 2006

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
Header	**ISA**	**Interchange Control Header**					**ISA must have fixed length data**
Header	ISA01	Authorization Information Qualifier	ID2	"**00**" = No Authorization Information Present	Literal	Required	
Header	ISA02	Authorization Data Identification	AN10	[**ten spaces**] - No Meaningful Information	Literal	Required	
Header	ISA03	Security Information Qualifier	ID2	"**00**" = No Security Information Present	Literal	Required	
Header	ISA04	Security Information	AN10	[**ten spaces**] - No Meaningful Information	Literal	Required	
Header	ISA05	Interchange ID Qualifier	ID2	<Configured Sender's ID type> Use "**ZZ**"	Configure	Required	See 837P IG Appendix B for valid values
Header	ISA06	Interchange Sender ID	AN15	<Configured Sender's ID> Use your 7-digit Trading Partner ID "**80XXXXX**"	Configure	Required	
Header	ISA07	Interchange ID Qualifier	ID2	<Configured Receiver's ID type> Use "**ZZ**"	Configure	Required	See 837P IG Appendix B for valid values
Header	ISA08	Interchange Receiver ID	AN15	"**100000**" followed by "spaces"	Literal	Required	
Header	ISA09	Interchange Date	DT6	<Derive current date>	Derive	Required	**YYMMDD**
Header	ISA10	Interchange Time	TM4	<Derive current time>	Derive	Required	**HHMM**
Header	ISA11	Interchange Control Standards Identifier	ID1	"**U**" = U.S. EDI	Literal	Required	
Header	ISA12	Interchange Control Version Number	ID5	"**00401**"	Literal	Required	
Header	ISA13	Interchange Control Number	N9	<Derive unique ID for all ISAs from this sender: timestamp precise to hundredths of a second>	Derive	Required	

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
Header	ISA14	Acknowledgement Request	ID1	<Default to: "**0**" = No Ack Requested>; "**1**" = Interchange Ack Requested	Use Default	Required	
Header	ISA15	Usage Indicator	ID1	<Configured usage> **P** = Production **T** = Test Data	Configure	Required	
Header	ISA16	Component Element Separator	1	" **:** " = Component Delimiter	Literal	Required	
Header	**GS**	**Functional Group Header**					**One functional group for each set of same transactions**
Header	GS01	Functional Identifier Code	ID2	"**HC**"-Health Care Claim (837)	Literal	Required	Depends on transaction
Header	GS02	Application Sender's Code	AN15	<Configure Sender's sub-division> Use your 7-digit Trading Partner ID number "**80XXXXX**"	Configure	Required	<ID for sub-div of ISA06>
Header	GS03	Application Receiver's Code	AN15	"**77045**"	Literal	Required	<ID for sub-div of ISA08>
Header	GS04	Date	DT8	<Derive current date>	Derive	Required	CCYYMMDD
Header	GS05	Time	TM8	<Derive current time>	Derive	Required	HHMM(SSDD)
Header	GS06	Group Control Number	N9	<Default to unique ID for each GS from this sender: timestamp precise to hundredths of a second>	Default	Required	Batch Number
Header	GS07	Responsible Agency Code	ID2	"**X**" = ASC X12	Literal	Required	
Header	GS08	Version/ Release/ Industry Identifier Code	AN12	"**004010X096A1**"	Literal	Required	Use addenda version "004010X096A1"

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
Header	**ST**	**Transaction Set Header**					
Header	ST01	Transaction Set Identifier Code	ID3	"**837**" - Health Care Claim	Literal	Required	
Header	ST02	Transaction Set Control Number	AN9	<Derive submitter sequence # from 1 by 1 for each transaction>	Derive	Required	
Header	**BHT**	**Beginning of Hierarchical Transaction**					
Header	BHT01	Hierarchical Structure Code	ID4	"**0019**" = Info Source, Subscriber, Dependent	Literal	Required	
Header	BHT02	Transaction Set Purpose Code	ID2	"**00**" = Original "**18**" = Reissue	Derive	Required	Electronic Transmission Status - **Original** = Never Sent to Receiver; **Reissue** = Transmission Disrupted, Sending Batch Again.
Header	BHT03	Originator Application Transaction Identifier	AN30	<Derive unique transmission ID from originator's system: timestamp precise to hundredths of a second>	Derive	Required	
Header	BHT04	Transaction Set Creation Date	DT8	<Default to current date if no claim submitted date>	Default	Required	CCYYMMDD
Header	BHT05	Transaction Set Creation Time	TM8	<Default to "**23595999**"-midnight>	Default	Required	HHMMSSDD
Header	BHT06	Claim or Encounter Identifier	ID2	"**RP**" = Encounter	Required	Required	**Always** use "RP"
Header	**REF**	**Transmission Type Identification**					

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Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
Header	REF01	Reference Identification Qualifier	ID3	"**87**" = Functional Category	Literal	Required	
Header	REF02	Transmission Type Code	AN30	"**004010X096A1**" = Production; "**004010X096DA1**" = Test	Derive	Required	
1000A	**NM1**	**Submitter Name**					**Submitter Loop is information about the MCO**
1000A	NM101	Entity Identifier Code	ID3	"**41**" = Submitter	Required	Required	
1000A	NM102	Entity Type Qualifier	ID1	<Configure MCO data> "**2**" = Non-person	Required	Required	**Always** Non-Person
1000A	NM103	Submitter Last or Organization Name	AN35	<Configure MCO data>	Required	Required	**Use MCO's Abbreviated Name** (ANH; CHPW; CUP; EVCR; GHC; MHC; RBS)
1000A	NM104	Submitter First Name	AN25	<Configure MCO data>	Not Required	Not Required	
1000A	NM105	Submitter Middle Name	AN25	<Configure MCO data>	Not Required	Not required	
1000A	NM108	Identification Code Qualifier	ID2	"**46**" = ETIN	Required	Required	Electronic Transmission Identification Number
1000A	NM109	Submitter Identifier	AN80	MCO Submitter ID number - "**80XXXXX**"	Required	Required	Same as the ACS EDI Gateway Trading Partner ID Number
1000A	**PER**	**Submitter EDI Contact Information**					**MCO Contact information**
1000A	PER01	Contact Function Code	ID2	Literal "**IC**"	Required	Required	Information Contact
1000A	PER02	Submitter Contact name	AN60	Name of Person to contact at the MCO regarding information in this submission	Required	Required	
1000A	PER03	Communication Number Qualifier	ID2	**EM** = Email Address; **TE** = Telephone Number	Required	Required	

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Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
1000A	PER04	Communication Number	AN80		Required	Required	
1000B	**NM1**	**Receiver Name**					**The Receiver Loop identifies DSHS/HRSA (MAA)**
1000B	NM101	Entity Identifier Code	ID3	"**40**" = Receiver	Literal	Required	
1000B	NM102	Entity Type Qualifier	ID1	"**2**" = Non-Person	Literal	Required	
1000B	NM103	Receiver Name	AN35	"**WA DSHS MAA**"	Literal	Required	MAA = HRSA
1000B	NM108	Identification Code Qualifier	ID2	"**46**" = ETIN	Literal	Required	Electronic Transmission Identification Number
1000B	NM109	Receiver Primary Identifier	AN80	"**77045**"	Literal	Required	
2000A	**HL**	**Billing Provider Hierarchical Level**					
2000A	HL01	Hierarchical ID Number	AN12	<increment from 1 by 1 for each HL segment in transaction>	Derive	Required	Increment from 1 by 1 for each HL segment in transaction
2000A	HL03	Hierarchical Level Code	ID2	"**20**" = Information Source	Literal	Required	
2000A	HL04	Hierarchical Child Code	ID1	"**1**" = Child HL Follows	Literal	Required	
2010AA	**NM1**	**Billing Provider Name**					**For Encounter Data Reporting the Billing Provider Loop will be used to identify the MCO and the Line of Business (HO, BH+, GAU, WMIP)**
2010AA	NM101	Entity Identifier Code	ID3	"**85**" = Billing Provider	Literal	Required	For Encounter Data Reporting the Billing Provider always = MCO
2010AA	NM102	Entity Type Qualifier	ID1	"1" = Person; "**2**" = Non-Person	Required	Required	**Always** 2 = Non-Person

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2010AA	NM103	Billing Provider Last or Organizational Name	AN35	>Organization Name <Configure MCO data	Required	Required	For Encounter Data reporting use MCO's Abbreviated Name **(GHC; MHC; CHPW; RBS; ANH; CUPP; KHPP etc)**
2010AA	NM108	Identification Code Qualifier	ID2	"**24**"= Employer ID; or "34"=SSN; or "XX" = NPI (future)	Required	Required	**Always** "24"
2010AA	NM109	Billing Provider Identifier	AN80	Standard Tax-ID for billing provider or future NPI	Required	Required	This is always the Tax ID or NPI of the MCO.
2010AA	**N3**	**Billing Provider Address**					
2010AA	N301	Billing Provider Address Line	AN55		Required	Required	**Always** the Address of the MCO reporting the data.
2010AA	N302	Billing Provider Address Line	AN55		Not required	Not required	
2010AA	**N4**	**Billing Provider City/State/ZIP Code**					
2010AA	N401	Billing Provider City Name	AN30		Required	Required	**Always** the City of the MCO reporting the data.
2010AA	N402	Billing Provider State or Province Code	ID2		Required	Required	
2010AA	N403	Billing Provider Postal Zone or ZIP Code	ID15		Required	Required	
2010AA	**REF**	**Billing Provider Secondary Identification**					
2010AA	REF01	Reference Identification Qualifier	ID3	"**1D**" = Medicaid Provider ID	Required	Required	

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2010AA	REF02	Billing Provider Additional Identifier	AN30	This must be the MCO's active 7-digit Medicaid Provider ID number "**75XXXXX**"	Required	Required	MCO Provider Medicaid Number for DSHS - the Medicaid ID number for the specific Line-of-Business (HO or BH+).
2010AB	**NM1**	**Pay-To-Provider Name**					**For Encounter Data - Always use the information of the healthcare provider who received PAYMENT for the services from the MCO**
2010AB	NM101	Entity Identifier Code	ID3	"**87**" = Pay-To-Provider	Literal	Required	**Always** "87"
2010AB	NM102	Entity Type Qualifier	ID1	"**1**" = Person; or "**2**" = Non-Person	Required	Required	
2010AB	NM103	Pay-To-Provider Last or Organizational Name	AN35	>Last Name / Org. Name <Configure MCO data	Required	Required	The name of the individual or organization who received payment for the services from the MCO
2010AB	NM104	Pay-To-Provider First Name	AN25	Individual's First Name	Required if a person		
2010AB	NM105	Pay-To-Provider Middle Name	AN25		Optional	Optional	
2010AB	NM107	Pay-To-Provider Name Suffix	AN10		Optional	Optional	
2010AB	NM108	Identification Code Qualifier	ID2	"**24**" = Employer ID or "**34**" = SSN or "**XX**" = NPI (future)	Required	Required	
2010AB	NM109	Pay-To-Provider Identifier	AN80	Standard Tax-ID or NPI for Pay-To-Provider	Required	Required	
2010AB	**N3**	**Pay-To-Provider Address**					

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2010AB	N301	Pay-To-Provider Address Line	AN55		Required	Required	
2010AB	N302	Pay-To-Provider Address Line	AN55		Not Required	Not Required	
2010AB	**N4**	**Pay-To-Provider City/State/ZIP Code**					
2010AB	N401	Pay-To-Provider City Name	AN30		Required	Required	
2010AB	N402	Pay-To-Provider State or Province Code	ID2		Required	Required	
2010AB	N403	Pay-To-Provider Postal Zone or ZIP Code	ID15		Required	Required	
2010AB	**REF**	**Pay-To-Provider Secondary Identification**					
2010AB	REF01	Reference Identification Qualifier	ID3	"**1D**" - Medicaid Provider ID	Required	Not Required	
2010AB	REF02	Pay-To-Provider Additional Identifier	AN30	The 7-digit DSHS Assigned Medicaid ID number for the individual provider who received payment for the healthcare service.	Required	Not Required	This must be a valid and **active** Medicaid Provider ID number for the date(s) of service. "8999070" default okay up to 25%.
2000B	**HL**	**Subscriber Hierarchical Level**					**Validate sequence #s to ensure correct structure**
2000B	HL01	Hierarchical ID Number	AN12	<increment from 1 by 1 for each HL segment in transaction>	Derive	Required	
2000B	HL02	Hierarchical Parent ID Number	AN12	<HL01 value of parent HL segment>	Derive	Required	Parent HL01 value
2000B	HL03	Hierarchical Level Code	ID2	"**22**" = Subscriber	Literal	Required	

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2000B	HL04	Hierarchical Child Code	ID1	"**0**" = no subordinate HL segments	Literal	Required	Patient is **Always** the Subscriber
2000B	**SBR**	**Subscriber Information**					**The Subscriber is the MCO member receiving the service**
2000B	SBR01	Payer Responsibility Sequence Number code	ID1	"**P**" = Primary	Literal	Required	For Encounter Data - **always** use "P"
2000B	SBR02	Individual Relationship Code	ID2	"**18**" = Self	Required if subscriber = patient	Required if subscriber = patient	"18"-Self, or nothing
2000B	SBR09	Claim Filing Indicator Code	ID2	"**MC**"-Medicaid	Literal	Required	
2010BA	**NM1**	**Subscriber Name**					
2010BA	NM101	Entity Identifier Code	ID3	"**IL**" = Insured	Literal	Required	
2010BA	NM102	Entity Type Qualifier	ID1	"**1**" = Person	Literal	Required	
2010BA	NM103	Subscriber Last Name	AN35	Subscriber Last Name	Required	Required	
2010BA	NM104	Subscriber First Name	AN25	Subscriber First Name	Required	Required	
2010BA	NM105	Subscriber Middle Name/Initial	AN25	Subscriber Middle Name/Initial	Required if known	Required if known	
2010BA	NM108	Identification Code Qualifier	ID2	"**MI**" = Member ID	Literal	Required if subscriber = patient	
2010BA	NM109	Subscriber Primary Identifier	AN80	**PIC** (For DSHS - The PIC is always the primary identifier of the subscriber).	Required	Required	Enter the Medicaid assigned Patient Identification Code (PIC) using the Display Format – e.g. John Q Public: **JQ083104PUBLIA**
2010BA	**N3**	**Subscriber Address Information**					
	N301	Subscriber Address Line	AN55	Subscriber Address Line	Required	Required	

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
	N302	Second line Subscriber Address	AN55	Second line Subscriber Address	Required	Required	
2010BA	**N4**	**Subscriber City/State/Zip Code**					
	N401	Subscriber City Name	AN30	Subscriber City Name	Required	Required	
	N402	Subscriber State Code	ID2	Subscriber State Code	Required	Required	
	N403	Subscriber Zip Code	ID15	Subscriber Zip Code	Required	Required	
2010BA	**DMG**	**Subscriber Demographic Information**					
2010BA	DMG01	Date Time Period Format Qualifier	ID3	"**D8**" = CCYYMMDD	Literal	Required	
2010BA	DMG02	Subscriber Birth Date	AN35	Subscriber's Birth date	Required	Required	CCYYMMDD
2010BA	DMG03	Subscriber Gender Code	ID1	"**M**" = Male; "**F**" = Female; "**U**" = Unknown	Required if Subscriber = Patient	Required	
2010BA	**REF**	**Subscriber Secondary Identification**					
2010BA	REF01	Reference Identification Qualifier	ID3	"**SY**"-SSN	Literal	Not required	
2010BA	REF02	Subscriber Supplemental Identifier	AN30	Subscriber's **SSN**	Required	Not required	For Encounter Data reporting the Subscriber's SSN is required to help correctly identify the client. Hard code okay - "123456789" if not available.
2010BC	**NM1**	**Payer Name**					**For Encounter Data Claims, MAA will always be the "Payer"**
2010BC	NM101	Entity Identifier Code	ID3	"**PR**" = Payer	Required	Required	
2010BC	NM102	Entity Type Qualifier	ID1	"**2**" = Organization	Required	Required	

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2010BC	NM103	Payer Name - Name Last/Org. Name	AN35	**"WA DSHS MAA"**	Required	Required	Washington State Medicaid - HRSA (MAA) is **always** the payer
2010BC	NM108	Identification Code Qualifier	ID2	"**PI**"-Payer's ID	Required	Required	
2010BC	NM109	Payer Identifier	AN80	**"77045"**	Required	Required	Enter HRSA's Payer Identifier for EDI
2300	**CLM**	**Claim information**					**This segment applies to the entire Encounter Record - Recommended Max is 5000**
2300	CLM01	Claim Submitter's Identifier (also known as the Patient Account Number/Patient Control Number)	AN38	Claim Number from the MCO's Claim Payment System	Required	Required	This number will be returned to the MCO on the Encounter Results Transaction (ERT) after MAA's Encounter Data validation processing.
2300	CLM02	Total Claim Charge Amount	R18	Total Claim Charge Amount	Required	Required	
2300	**CLM05**	**Health Care Service Location Information**					
2300	CLM05-1	Facility Code Value	AN2	Facility Type Code	Required	Required	**See Spreadsheet Tab - CLM05-1 for Acceptable values - These codes are from the NUBC code source**
2300	CLM05-2	Facility Code Qualifier	ID2	"**A**" = UB Bill Type	Literal	Required	
2300	CLM05-3	Claim Frequency Code	ID1	"**1**" = Original Encounter record; "**7**" = Replace previously accepted Encounter Record	Required	Required	Use "**7**" when submitting corrections and replacing previously submitted Encounter Records.

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2300	CLM06	Provider/Supplier Signature Indicator	ID1	"**N**" (Default)	Literal	Required	**Always** use "N" for encounter data reporting
2300	CLM07	Provider Accept Assignment Code	ID1	"**C**" (Default)	Literal	Required	**Always** use "C" for encounter data reporting
2300	CLM08	Benefits Assignment Cert Indicator	ID1	"**Y**" (Default)	Literal	Required	**Always** use "Y" for encounter data reporting
2300	CLM09	Release of Information Code	ID1	"**Y**" (Default)	Literal	Required	**Always** use "Y" for encounter data reporting
2300	CLM 18	EOB Indicator	ID1	"**N**" (Default)	Literal	Required	**Always** use "N" for encounter data reporting
2300	**DTP**	**Discharge Hour**					
2300	DTP01	Date Time Qualifier	ID3	"**096**" = Discharge	Literal	Required if final claim	
2300	DTP02	Date Time Period Format Qualifier	ID3	"**TM**" = HHMM	Literal	Required if final claim	
2300	DTP03	Discharge Hour	AN35	**HHMM**		Required if Inpatient final claim	
2300	**DTP**	**Statement Dates**					
2300	DTP01	Date Time Qualifier	ID3	"**434**"- Statement	Literal	Required	
2300	DTP02	Date Time Period Format Qualifier	ID3	"**D8**" = Single Date; or "**RD8**" = From - To Dates	Use "RD8"	Required	"D8"-CCYYMMDD, "RD8"-CCYYMMDD-CCYYMMDD
2300	DTP03	Statement From Date	AN35	CCYYMMDD - CCYYMMDD	Required: statement from/to may differ from admit/discharge date	Required	**Inpatient =** admit to discharge unless CL103=9 or 30-39 (not discharged)
2300	**DTP**	**Admission Date/Hour**					
2300	DTP01	Date Time Qualifier	ID3	"**435**" = Admission	Literal	Required for Inpatient services	

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Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2300	DTP02	Date Time Period Format Qualifier	ID3	"**DT**"	Literal	Required for Inpatient services	
2300	DTP03	Admission Date and Hour	AN35	Hospital Admission Date and Hour - **CCYYMMDDHHMM**	Required for Inpatient services	Required for Inpatient services	Hard Code okay for HHMM information "0100". Do Not zero fill.
2300	**CL1**	**Institutional Claim Code**					
2300	CL101	Admission Type Code	ID1	"**1**" = ER; "**2**" = Urgent; "**3**" = Elective/by appt; "**4**" = Newborn	Required for Inpatient services	Required for Inpatient services	
2300	CL102	Admission Source Code	ID1	Admit source valid values	Required for Inpatient services	Required for Inpatient services	See Spreadsheet Tab - CL102, Admit Source for valid values
2300	CL103	Patient Status Code	ID2	Patient Destination on Discharge - CL103-Patient Status	Required if Inpatient	Required if Inpatient	See Spreadsheet Tab - CL103, Patient Status for valid codes
2300	**REF**	**Original Reference Number (ICN/DCN)**					
2300	REF01	Reference Identification Qualifier	ID3	"**F8**" = Original Reference Number	Literal	Required if resubmitting a previously accepted Encounter Record	Use ONLY when the Claim Frequency Code in CLM05-3 equals "7".
2300	REF02	Claim Original Reference Number	AN30	Reference the "**Original/Previous**" ICN number assigned by HRSA to the originally submitted Encounter record	Required when the Claim Frequency Code in CLM05-3 equals "**7**"	Required only when resubmitting a corrected Encounter record to replace a previously submitted Encounter.	Use ONLY when the Claim Frequency Code in CLM05-3 equals "**7**".

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Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2300	**NTE**	**Billing Note**					
2300	NTE01	Note Reference Code	ID3	Literal "**ADD**"	Required if denied SVC line items in claim	Not Required	Use only "ADD"
2300	NTE02	Billing Note Text	AN80	Denied line items	Required if denied SVC line items in claim	Not Required	Report Denied Line Items here. Use the letter D as your delimiter between 3-digit line numbers, no spaces. (i.e. D###). If >18 denied lines do not report claim until the final adjudication.
2300	**CR6**	**Home Health Care Information**		**Follow IG instructions for Home Health Service encounter records**	**This segment required ONLY IF claim is for Home Health Services**	**Follow IG instructions**	
2300	CRC	Home Health Functional Limitations		Follow IG instructions for Home Health Service encounter records	This segment required ONLY IF claim is for Home Health Services	Follow IG instructions	
2300	CRC	Home Health Activities Permitted		Follow IG instructions for Home Health Service encounter records	This segment required ONLY IF claim is for Home Health Services	Follow IG instructions	
2300	CRC	Home Health Mental Status		Follow IG instructions for Home Health Service encounter records	This segment required ONLY IF claim is for Home Health Services	Follow IG instructions	

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Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2300	**HI**	**Principal, Admitting, E-Code and Patient Reason For Visit Diagnosis Information**					
2300	HI01	Health Care Code Information					
2300	HI01-1	Code List Qualifier Code	ID3	"**BK**"- Principal ICD9 Diagnosis	Required	Required	Use for both Inpatient **AND** Outpatient encounters
2300	HI01-2	Industry Code	AN30	ICD.9 - Principal Diagnosis Code	Required	Required	
2300	HI02	Health Care Code Information					
2300	HI02-1	Code List Qualifier Code	ID3	"**BJ**" = Admitting Diagnosis; "**ZZ**"-Reason for Visit	Required		Admit Diagnosis = **Inpatient** Admit; Visit Reason = Unscheduled **Outpatient** Visit
2300	HI02-2	Industry Code	AN30	ICD.9 - Admitting Diagnosis Code, or Patient Reason For Visit	Required	Required on all unscheduled Outpatient visits	Admit ICD.9 code (Required on all **Inpatient Admission** claims/ Encounter records) or Reason Code.
2300	**HI03**	**Health Care Code Information**					
2300	HI03-1	Code List Qualifier Code	ID3	"**BN**" = US DHHS E-Code	Required if injury, poison or adverse effect	Required if injury, poison or adverse effect	
2300	HI03-2	Industry Code	AN30	ICD.9 E-Code			

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2300	**HI**	**Diagnosis Related Group (DRG) Information**				**Required when Inpatient hospital is under a DRG contract with the biller/MCO.**	
2300	HI01	Health Care Code Information					
2300	HI01-1	Code List Qualifier Code	ID3	"**DR**" = DRG	Literal	Required	
2300	HI01-2	Diagnosis Related Group (DRG) Code	AN30	**DRG Code**	Required	Required	Use if Inpatient claim was paid using a DRG
2300	**HI**	**Other Diagnosis Information**					**Repeat segment up to 8 times as needed**
2300	HI01	Health Care Code Information					
2300	HI01-1	Code List Qualifier Code	ID3	"**BF**" = Diagnosis	Literal	Required if other conditions exist	
2300	HI01-2	Other Diagnosis	AN30	Other Diagnosis Codes – ICD.9 code	Required if other conditions exist	Required if other conditions exist	
2300	**HI**	**Principal Procedure Information**					**Required on all Inpatient claims when a procedure was performed and on Home IV therapy claims when surgery was performed during the Inpatient which resulted in initiating the course of therapy**
2300	HI01	Health Care Code Information					

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2300	HI01-1	Code List Qualifier Code	ID3	"**BP**" = HCPCS/CPT code; "**BR**" = ICD9-CM Principal Procedure Code	Required	Required	
2300	HI01-2	Industry Code	AN30	Principal Procedure Code	Required	Required	**HCPCS / CPT Procedure Code = Outpatient;** ICD-9-CM Procedure Code = Inpatient
2300	HI01-3	Date Time Period Format Qualifier	ID3	"**D8**"	Required	Required	Required when HI01-1 = "BR"
2300	HI01-4	Date	AN35	Format Date = **CCYYMMDD**			
2300	**HI**	**Other Procedure Information**					**Required on all Inpatient claims when a procedure was performed and on Home IV therapy claims when surgery was performed during the Inpatient which resulted in initiating the course of therapy**
2300	HI01	Health Care Code Information					
2300	HI01-1	Code List Qualifier Code	ID3	"**BO**" = HCPCS / CPT code; "**BQ**" = ICD9-CM Procedure Code	Required	Required	
2300	HI01-2	Industry Code	AN30	Other Procedure Codes	Required	Required	**HCPCS / CPT Procedure Code = Outpatient**; ICD-9-CM Procedure Code = Inpatient
2300	HI01-3	Date Time Period Format Qualifier	ID3	"**D8**"	Required when HI01-1 = "BQ"	Required when HI01-1 = "BQ"	

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2300	HI01-4	Date	AN35	Format Date = **CCYYMMDD**			
2300	**HI**	**Other Procedure Information**					**Repeat this HI segment up to 12 times to report other procedure codes with the same required information listed in the above HI segment**
2300	HI	Value Information		Required when value information applies to the claim/encounter			Use this segment to report Newborn Birth Weight found using the UB-92 code set
2300	HI01	Health Care Code Information					
2300	HI01-1	Code List Qualifier Code	ID3	"**BE**"	Literal	Required	Use when Admission Type Code in CL101 = "**4**" Newborn
2300	HI01-2	Value Code	AN30	"**54**"	Required	Required	Use when Admission Type Code in CL101 = "**4**" Newborn
2300	HI01-5	Monetary Amount	R18	Newborn Birth Weight **in grams**	Required	Required	Include Newborn Birth Weight; when Admission Type Code in CL101 = "4" Newborn
2310A	**NM1**	**Attending Physician Name**					
2310A	NM101	Entity Identifier Code	ID3	"**71**" = Attending Physician	Literal	Required	Use when Inpatient or HH primary physician
2310A	NM102	Entity Type Qualifier	ID1	"**1**" = Person; "**2**" = Non-Person	Literal	Required if Inpatient or HH primary physician	
2310A	NM103	Attending Physician Last Name	AN35		Required if a person	Required if a person	

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2310A	NM104	Attending Physician First Name	AN25		Required if a person	Required if a person	
2310A	NM105	Attending Physician Middle Name	AN25		Optional	Not required	
2310A	NM107	Attending Physician Name Suffix	AN10		Optional	Not required	
2310A	NM108	Identification Code Qualifier	ID2	"**24**"-EIN (Fed Tax ID); "**34**"-SSN; "**XX**"-NPI (future)	Required if Inpatient or HH Primary Physician	Required if Inpatient or HH Primary Physician	
2310A	NM109	Attending Physician Primary Identifier	AN80	EIN; SSN; or NPI	Required if Inpatient or HH Primary Physician	Required if Inpatient or HH Primary Physician	Okay to hard code if unknown
2310A	**REF**	**Attending Physician Secondary Identification**					
2310A	REF01	Reference Identification Qualifier	ID3	"**1D**" = Medicaid ID	Required	Required	
2310A	REF02	Attending Physician Secondary Identifier	AN30	The 7-digit DSHS Assigned Medicaid ID number for the individual provider who provided the healthcare service.	Required	Required	This must be a valid and **active** Medicaid Provider ID number for the date(s) of service. "8999070" default okay up to 25%.
2400	**LX**	**Service Line Number**					
2400	LX 01	Assign Number	N06	Line Item Number	Required	Required	<Must derive sequential # from 1 by 1 for each service line>
2400	**SV2**	**Institutional Service Line**					

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2400	SV201	Service Line Revenue Code	AN48	Revenue Code	Required	Required	Use for Inpatient or Outpatient services See code source - NUBC Codes
2400	SV202	Composite Medical Procedure Identifier		See IG	Required	Required	For Outpatient Encounters when HCPCS exists at line level.
2400	**SV202-1**	**Product or Service ID Qualifier**	**ID2**	**HCPCS / CPT Qualifier codes (See IG for valid values)**		**Required if Outpatient and HCPCS/CPT exists**	
2400	SV202-2	Procedure Code	AN48	Primary Procedure Code	Required if Outpatient	Required if Outpatient	Outpatient must be HCPCS / CPT procedure code, not ICD9 procedure code
2400	SV202-3	Procedure Modifier	AN2	Procedure Code Modifier	Required if Outpatient and clarifies the procedure	Required if Outpatient and clarifies the procedure	Repeat up to 4 times to report all Modifiers
2400	SV203	Line Item Charge Amount	R18	Line Billed Charges	Required	Required	Zero amount is acceptable value/ Total charges by Rev code
2400	SV204	Unit or Basis for Measurement Code	ID2	"**DA**" = Days; "**F2**" = IU; "**UN**" = Units (default)	Required	Required	See IG for valid values
2400	SV205	Service Unit Count	R15	Units of Service	Required	Required	
2400	SV206	Service Line Rate	R10	Rate for Room & Board Revenue Codes	Required	Required	Required on all Inpatient Encounters when a Revenue code is for Room & Board.
2400	**DTP**	**Service Line Date**					
2400	DTP01	Date Time Qualifier	ID3	"**472**" = Date of Service	Literal	Required if Outpatient	
2400	DTP02	Date Time Period Format Qualifier	ID3	"**D8**"; or "**RD8**"		Required if Outpatient	

BLUE = Segment Title

Loop	Segment	ASC X12N Name	Data Type and Length	ASC X12N 837 I Data Content	DSHS Requirement	837 I Implementation Guide (IG) Requirements	Comments
2400	DTP03	Service Date	AN35	From Date of Service = **CCYYMMDD**		Required if Outpatient	
Trailer	**SE**	**Transaction Set Trailer**					
Trailer	SE 01	Transaction Segment Count	N010		Derive	Required	Number of segments in transaction
Trailer	SE 02	Transaction Set Control Number	AN9		Derive	Required	same as ST02
Trailer	**GE**	**Functional Group Trailer**					
Trailer	GE01	Number of Transaction Sets Included	N6		Derive	Required	Count number of transactions in group
Trailer	GE02	Group Control Number	N9		Derive	Required	Unique ID for each GS/GE from this sender
Trailer	**IEA**	**Interchange Control Trailer**					
Trailer	IEA01	Number of Included Functional Groups	N5	"**1**"-one functional group in interchange	Derive	Required	
Trailer	IEA02	Interchange Control Number	N9	<Derive: same as ISA13>	Derive	Required	Unique ID for each ISA/IEA from this sender

ADMIT SOURCE - CL102	
Code	**Description**
1	physician referral
2	clinic referral
3	HMO referral
4	transfer from a hospital
5	transfer from a SNF
6	transfer from another health care facility
7	ER
8	court/law enforcement
9	info not avail
A	transfer from a rural primary care hospital

IF CL101 - ADMIT TYPE = 4-newborn	
1	normal delivery
2	premature delivery
3	sick baby
4	extramural birth

PATIENT STATUS CODES - CL103 National Uniform Billing Data Element Specifications	
Code	**Description**
01	Discharge to home or self-care (Routine Discharge)
02	Discharged/transferred to another short-term general hospital for Inpatient care
03	Discharged/transferred to a skilled nursing facility (SNF)
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of institution for Inpatient care
06	Discharged/transferred to home under the care of home health service organization
07	Left against medical advice
08	Discharged/transferred to home with Home IV svc.
09	Admitted as Inpatient
10-19	Discharge destination defined by state
20	Expired
21-29	Expired defined by state
30	Still patient
31-39	Still patient defined by state
40	Expired at home
41	Expired in a medical facility
42	Expired, place unknown
50	Hospice-home
51	Hospice-medical facility
61	Discharged within facility to Medicare bed
71	Discharged to another institution for outpatient services
72	Discharged to this facility for outpatient services

FACILITY TYPE OR BILL TYPE - CLM05	
1st digit	**Description**
1	Hospital
2	Skilled Nursing
3	Home Health
4	Christian Science (hospital)
5	Christian Science (extended care)
6	Intermediate care
7	Clinic
8	Special facility
9	Reserved for national use
2nd digit	**Description**
1	Inpatient (Medicare Part A)
2	Inpatient (Medicare Part B only)
3	Outpatient
4	Other
5	Intermediate Care Level
6	Intermediate Care Level
7	Intermediate Care Level
8	Swing beds
9	Reserved for national use

The second digit has different definitions associated with the valid values based on what is billed for the 1st digit.

3rd digit	**Description**
1	Admit Through Discharge Claim
2	Interim - First Claim
3	Interim - Continuing Claim
4	Interim - Last Claim
5	Late Charges(s) Only Claim

Field	Field Name	Status	Type	Length	Value/Format
HEADER					
880 – K4	Text Indicator	M	A/N	1	Start of Text (Stx) = X'02'
701	Segment Identifier	M	A/N	2	00 = File Control (Header)
880-K6	Transmission Type	M	A/N	1	T = Transaction R = Response E = Error
880-K1	Sender ID	M	A/N	24	Use the MCO's 7 Digit Medicaid Provider ID (750XXXX) for each Line-Of-Business (HO/SCHIP; BH+; GAU, etc.).
806-5C	Batch Number	M	N	7	Must be 7 numeric characters, sequentially numbering the batches and must match Trailer record.
880-K2	Creation Date	M	N	8	Format = CCYYMMDD
880-K3	Creation Time	M	N	4	Format = HHMM
702	File Type	M	A/N	1	P = Production T = Test
102-A2	Version / Release Number	M	A/N	2	Version/ Release of Header Data = 11
880-K7	Receiver Id	M	A/N	24	Blank
880-K4	Text Indicator	M	A/N	1	End of Text (Etx) = X'03'
	CRLF	M			X'0D'X'0A'
DETAIL DATA RECORD					
880-K4	Text Indicator	M	A/N	1	Start of Text (Stx) = X'02'
701	Segment Identifier	M	A/N	2	G1 = Detail Data Record
880-K5	Transaction Reference Number	M	A/N	10	This number is assigned by the PBM/MCO to uniquely identify each claim within the file. If Encounter Records are rejected this number will be returned on the ERT to identify the claim.
101–A1	BIN Number	M	N	6	610084
102–A2	Version/Release Number	M	A	2	51

Field	Field Name	Status	Type	Length	Value/Format
103–A3	Transaction Code	M	N	2	B1 = Billing B2 = Reversal – The edit program will search history and flag reversals as void. B3 = Rebill – use for reporting HRSA corrected, rejected pharmacy claims
104–A4	Processor Control Number	M	A	10	DRWAPROD – for Prod claims DRWAACCP – for Test claims
109-A9	Transaction Count	M	A/N	1	1 = One Transaction 2 = Two Transactions 3 = Three Transactions 4 = Four Transactions - See Paragraph 8.2.3 of the Telecommunication Standard Specifications - Version 5 Release 1
202–B2	Service Provider ID Qualifier	M	A/N	2	07 = NCPDP (NABP) ID# - (Always Use 07)
201–B1	Service Provider ID	M	A/N	15	NCPDP (NABP) Provider ID#
401–D1	Date of Service	M	N	8	CCYYMMDD
110–AK	Software Vendor Certification ID	M	A/N	10	Populate with 10 zeros
SS	Segment Separator (<1E>)		A	1	1E
FS	Field Separator (<FS> AM)		A	3	AM
111–AM	**Segment Identification**	**M**	**A/N**	**2**	**01 – Patient Segment**
FS	Field Separator (<FS> C4)		A	3	C4
304-C4	Date of Birth	R	N	8	CCYYMMDD
FS	Field Separator (<FS> C5)		A	3	C5

Field	Field Name	Status	Type	Length	Value/Format
305-C5	Gender Code	R	A/N	1	0=Not specified 1= Male 2=Female
FS	Field Separator (<FS>C7)		A	3	C7
307-C7	Patient Location	RW	N	2	See NCPDP Version 5.1 Valid Values
FS	Field Separator (<FS> 2C)		A	3	2C
335-2C	Pregnancy Indicator	RW	A/N	1	Blank = Not Specified 1 = Not Pregnant 2 = Pregnant
SS	Segment Separator (<1E>)		A	1	1E
FS	Field Separator (<FS>AM)		A	3	AM
111-AM	**Segment Identification**	**M**	**A/N**	**2**	**04 = Insurance Segment**
FS	Field Separator (<FS>C2)		A	3	C2
302-C2	Cardholder ID	M	A/N	20	Recipient's Medicaid Number: **Must use Client's 14 character PIC number**
FS	Field Separator (<FS>) C1		A	3	C1
301-C1	Group ID	R	A/N	15	This ID number identifies the claim as a Managed Care Encounter - Use list on NCPDP Group ID # - See NCPDP Tab
FS	Field Separator (<FS>C6)		A/N	3	C6
306-C6	Patient Relationship Code	R	N	1	1 = Cardholder (Always = 1)

Field	Field Name	Status	Type	Length	Value/Format
GS	Group Separator (<1D>)		A	1	1D
SS	Segment Separator (<1E>)		A/N	2	1E
FS	Field Separator (<FS>) AM		A	3	AM
111-AM	**Segment Identification**	**M**	**A/N**	**2**	**07 = Claim**
FS	Field Separator (<FS>) EM		A	3	EM
455-EM	Prescription/Service Reference Number Qualifier	M	A/N	1	1 = Rx Billing (Paid by MCO)
FS	Field Separator (<FS>) D2		A	3	D2
402-D2	Prescription/Service Reference Number	M	N	7	Prescription Number or Leave Blank if none.
FS	Field Separator (<FS>E1)		A	3	E1
436-E1	Product/Service ID Qualifier	M	A/N	2	03 = National Drug Code
FS	Field Separator (<FS>D7)		A	3	D7
407-D7	Product/ Service ID	M	A/N	19	11-Digit NDC Number
FS	Field Separator (<FS>EN)		A	3	EN
456-EN	Associated Prescription/Service Reference #	RW	N	7	Required when reporting a partial fill
FS	Field Separator (<FS>EP)		A	3	EP
457-EP	Associated Prescription/Service Date	RW	N	8	CCYYMMDD - Required when reporting a partial fill

Field	Field Name	Status	Type	Length	Value/Format
FS	Field Separator (<FS>E7)		A	3	E7
442-E7	Quantity Dispensed	R	N	10	Metric decimal quantity; Implied decimal 9(7)v9(3) 30 units should be coded as 0000030000
FS	Field Separator (<FS>D3)		A	3	D3
403-D3	Fill Number	R	A/N	2	0 = Original Fill 1 - 99 = Refill Number
FS	Field Separator (<FS>D5)		A	3	D5
405-D5	Days Supply	R	N	3	# of Days Supply
FS	Field Separator (<FS>D6)		A	3	D6
406-D6	Compound Code	RW	N	1	0 = Not Specified 1 = Not a Compound 2 = Compound
FS	Field Separator (<FS>) D8		A	3	D8
408-D8	Dispense as Written (DAW)	RW	A/N	1	0 = No product selection 1 = Physicians Request
FS	Field Separator (<FS>DE)		A	3	DE
414-DE	Date Prescription Written	M	N	8	CCYYMMDD
FS	Field Separator (<FS>DK)		A	3	DK
420-DK	Submission Clarification Code	RW	N	2	Default = '0' Used only if claim submission requires clarification; 8 = Process Compound for Approved Ingredients Only

Field	Field Name	Status	Type	Length	Value/Format
FS	Field Separator (<FS>) C8		A	3	C8
308-C8	Other Coverage Code	RW	N	2	Default – '0'; Report if known. See NCPDP V5.1 for Valid Values
FS	Field Separator (<FS> DT)		A	3	DT
429-DT	Unit Dose Indicator	RW	N	1	Report if known - 3 = Pharmacy Unit Dose
FS	Field Separator (<FS>EU)		A	3	EU
461-EU	Prior Authorization Type code	RW	N	2	Report if known. Report if known - 2 = Self Referred 5 = Lost or stolen medication replacement 8 = supply for take home, school or camp, suicide risk or monitoring
FS	Field Separator (<FS>EV)		A	3	EV
462-EV	Prior Authorization Number Submitted	RW	N	11	Use the MCO Prior Authorization number or Default = '0'.
FS	Field Separator (<FS>HD)		A	3	HD
343-HD	Dispensing Status	RW	N	1	P = Initial Fill C =Completion Fill
FS	Field Separator (<FS>) HF		A	3	HF
344-HF	Quantity Intended to be Dispensed	RW	N	10	Same as metric decimal quantity Implied decimal 9(7)v9(3)
FS	Field Separator (<FS>HG)		A	3	HG

Field	Field Name	Status	Type	Length	Value/Format
345-HG	Days Supply Intended to be dispensed	RW	N	3	
SS	Segment Separator (<1E>)		A	1	1E
FS	Field Separator (<FS>)AM		A	3	AM
111-AM	**Segment Identification**	**M**	**A/N**	**2**	**03 = Prescriber Segment**
FS	Field Separator (<FS>)EZ		A	3	EZ
466-EZ	Prescriber ID Qualifier	R	A/N	2	05 = Medicaid ID 12 = DEA Number
FS	Field Separator (<FS>DB)		A	3	DB
411-DB	Prescriber ID	R	A/N	15	The 7-digit Medicaid ID or DEA Number of the Prescribing Physician if known. Use 8999070 if ID not known.
SS	Segment Separator (<1E>)		A	1	1E
FS	Field Separator (<FS>AM)		A	3	AM
111-AM	**Segment Identification**	**M**	**A/N**	**2**	**05 – COB / Other Payments**
FS	Field Separator (<FS>4C)		A	3	4C
337-4C	Coordination of Benefits / Other Payments (count)	M	N	1	Count of other payment occurrences.
FS	Field Separator (<FS>5C)		A	3	5C
388-5C	Other Payer Coverage Type	M (Repeating)	A/N	2	See NCPDP V5.1 for Valid Values

Field	Field Name	Status	Type	Length	Value/Format
FS	Field Separator (<FS>6C)		A	3	6C
339-6C	Other Payer ID Qualifier	RW (Repeating)	A/N	2	See NCPDP V5.1 for Valid Values
340-7C	Other Payer ID	RW (Repeating)	A/N	10	ID assigned to other payer.
FS	Field Separators (<FS>E8)		A	3	E8
443-E8	Other Payer Date	RW	N	8	CCYYMMDD
FS	Field Separator (<FS>HB)		A	3	HB
341-HB	Other Payer Amount Paid	RW (Repeating)	N	1	MCO Paid Amount; If Reported S$$$$$$cc
FS	Field Separator (<FS>HC)		A	3	HC
342-HC	Other Payer Amount Paid Qualifier	RW (Repeating)	N	2	See NCPDP V5.1 for Valid Values
FS	Field Separator (<FS>DV)		A	3	DV
431-DV	Other Payer Amount Paid	RW (Repeating)	N	8	S$$$$$$cc; (example: $5.27 = 52G or $32.56 = 325F) Implied decimal 9(6)v99
SS	Segment Separator (<1E>)		A	1	1E
FS	Field Separator (<FS>) AM		A	3	AM
111-AM	**Segment Identification**	**M**	**A/N**	**2**	**08 – DUR / PPS Segment**
FS	Field Separator (<FS>) E4		A	3	E4
439-E4	Reason For Service Code	RW (Repeating)	A/N	2	See NCPDP V5.1 for Valid Values

Field	Field Name	Status	Type	Length	Value/Format
FS	Field Separator (<FS>) E5		A	3	E5
440-E5	Professional Service Code	RW (Repeating)	A/N	2	See NCPDP V5.1 for Valid Values
FS	Field Separator (<FS>) E6		A	3	E6
441-E6	Result of Service Code	RW (Repeating)	A/N	2	See NCPDP V5.1 for Valid Values
SS	Segment Separator (<1E>)		A	1	1E
FS	Field Separator (<FS>AM)		A	3	AM
111-AM	**Segment Identification**	**M**	**A**	**2**	**11 = Pricing Segment**
FS	Field Separator (<FS>) D9		A	3	D9
409-D9	Ingredient Cost Submitted	R	N	8	Implied decimal 9(6)v99
FS	Field Separator (<FS>DX)		A	3	DX
433-DX	Patient Paid Amount		N	6	Implied decimal 9(6)v99
FS	Field Separator (<FS>DQ)		A	3	DQ
426-DQ	Usual and Customary Charge	R	N	6	Implied decimal 9(6)v99
FS	Field Separator (<FS>DU)		A	3	DU
430-DU	Gross Amount Due	R	N	6	Total Billed Charges; s$$$$$$cc (example: $5.27 = 52G or $32.56 = 325F) Implied decimal 9(6)v99

Field	Field Name	Status	Type	Length	Value/Format
SS	Segment Separator (<1E>)		A	1	1E
FS	Field Separator (<FS>AM)		A	3	AM
111-AM	**Segment Identification**	**M**	**A/N**	**2**	**10 = Compound Segment**
FS	Field Separator (<FS>EF		A	3	EF
450-EF	Compound Code Dosage Form	M	A/N	2	See NCPDP V5.1 for Valid Values
FS	Field Separator (<FS>EG)		A	3	EG
451-EG	Compound Dispensing Unit Form Indicator	M	N	1	See NCPDP V5.1 for Valid Values
FS	Field Separator (<FS>EH)		A	3	EH
452-EH	Compound Route of Administration	M	N	2	See NCPDP V5.1 for Valid Values
FS	Field Separator (<FS>EC)		A	3	EC
447-EC	Compound Ingredient Component Count	M (Repeating)	N	2	Count of Compound Product ID's (NDC's)
FS	Field Separator (<FS>RE)		A	3	RE
488-RE	Compound Product ID Qualifier	M (Repeating)	A/N	2	03 = NDC
FS	Field Separator (<FS>TE		A	3	TE
489-TE	Compound Product ID	M (Repeating)	A/N	19	11-digit NDC Number

Field	Field Name	Status	Type	Length	Value/Format
FS	Field Separator (<FS>ED		A	3	ED
448-ED	Compound Ingredient Quantity	M (Repeating)	N	10	Number of ingredients; Implied decimal 9(7)v9(3)
FS	Field Separator (<FS>EE)		A	3	EE
449-EE	Compound Ingredient Drug Cost	RW (Repeating)	N	8	Billed Charges; Implied decimal 9(6)v99
	CRLF				X'0D' 'X' '0A'
TRAILER					
880-K4	Text Indicator		A/N	1	Start of Text (Stx) = X'02'
701	Segment Identifier		A/N	2	99 = File Trailer
806-5C	Batch Number		N	7	Matches Header
751	Record Count		N	10	
504-F4	Message		A/N	10	
880-K4	Text Indicator		A/N	1	End of Text (Etx)=X'03'
	CRLF				X'0D'X'0A'

ERROR #	ERROR MESSAGE	ERROR FLAG	ACS FIELD NAME	EDIT CRITERIA
1	FACILITY CODE IS INVALID FOR CLAIM TYPE	EDIT-FLG-ENC-TYPE	CLM-INPUT-FORM-IND (Encounter Type Indicator) **System Assigned**	Record Code is equal to '61'; and Facility Code is not equal to '11' or '13' • Record Code equals '60' set Claim Input Form Indicator to 'J'. • Record Code equals '61' and Facility Code is equal to '11' set Claim Input Form Indicator to 'R'. • Record Code equals '61' and Facility Code is equal to '13' set Claim Input Form Indicator to 'M'. • Record Code equals '62' set Claim Input Form Indicator to 'D'.
2	SUBMITTED RECIPIENT ID IS EQUAL TO SPACES	EDIT-FLG-PIC-1	ORIGINAL-RECIP-ID (PIC) Rejection Edit	PIC is equal to spaces.
3	SUBMITTED RECIPIENT ID IS EQUAL TO ZEROES	EDIT-FLG-PIC-2	Rejection Edit	PIC is equal to zeroes.
4	SUBMITTED RECIPIENT ID IS NOT ON ELIGIBILITY FILE	EDIT-FLG-PIC-3	Rejection Edit	PIC is not on Recipient Master File or PIC is invalid
5	RECIP DATE OF BIRTH EQUALS ZEROES	EDIT-FLG-DATE-BIRTH	RECIP-DATE-OF-BIRTH (Date of Birth) Rejection Edit	Date of Birth is equal to zeroes.
6	PAY-TO-PROV ID INVALID OR NOT ON FILE; (previously MCO Prov Number Invalid Or Not On File)	EDIT-FLG-PAY-TO-ID	PAY-TO-PROV-ID (Pay-To ID) Info Flag Only	Pay-to Provider is not numeric, or Pay-to Provider is equal to zeroes, or Pay-to Provider is equal to 8888888, or Pay-to g Provider is equal to 9999999; or Pay-to Provider is not found in MMIS Master File.
7	BILLING PROV/MCO ID INVALID OR MISSING	EDIT-FLG-PROV-NUM	PROV-NUMBER (Billing/MCO ID Medicaid Number) Rejection Edit	Billing/MCO ID is not numeric, or MCO ID is equal to zeroes, or MCO ID is equal to 8888888, or MCO ID is equal to 9999999; or MCO ID is not on Provider Master File, or MCO ID is invalid.
8	RENDERING/ATTENDING PROV ID INVALID OR MISSING	EDIT-FLG-PERF-NBR	PERF-PRESC-ATT-PROV (Rendering/Attending (Performing) or Prescribing Provider Medicaid Number) Info Flag Only	Rendering/Attending (Performing) Provider is not numeric, or Rendering/Attending (Performing) Provider is equal to zeroes, or Rendering/Attending (Performing) Provider is equal to 8888888, or Rendering/Attending (Performing) Provider is equal to 9999999; or Rendering/Attending (Performing) Provider is not found in MMIS Master File.
9	ADMISSION DATE INVALID	EDIT-FLG-ADMIT-DATE	ADMISSION-DATE (Hospital Admission Date) Rejection Edit	Encounter Type Indicator is equal to 'R'; and Hospital Admission Date equal to zeros. EDI verifies date fields

ERROR #	ERROR MESSAGE	ERROR FLAG	ACS FIELD NAME	EDIT CRITERIA
10	PATIENT STATUS IS NOT VALID	EDIT-FLG-PATIENT-STATUS	PATIENT-STATUS (Patient Destination on Discharge) Rejection Edit	Encounter Type Indicator is equal to 'R'; and Patient Status is not equal to a value on the Patient Status valid values table (W031601)
11	FIRST DATE OF SERVICE IS INVALID	EDIT-FLG-FIRST-DATE-SVC-1	FIRST-DATE-OF-SVC (Date of Service) Rejection Edit	Date of Service is equal to zeros.
12	FIRST DATE OF SERVICE IS INVALID FOR AGE CALC	EDIT-FLG-FIRST-DATE-SVC-2	FIRST-DATE-OF-SVC (Date of Service) Info Flag Only	DSHS will provide criteria EDI verifies date fields
13	HOSPITAL DISCHARGE DATE IS INVALID	EDIT-FLG-LAST-DATE-SVC	LAST-DATE-OF-SVC (Hospital Discharge Date) Rejection Edit	Encounter Type Indicator is equal to an 'R' and Hospital Discharge Date is equal to zeroes. EDI verifies date fields
14	PLACE OF SERVICE IS NOT VALID	EDIT-FLG-PLACE-SVC2	PLACE-OF-SERVICE-2 (Place of Service) Rejection Edit	Record Code is '60' & Place of Service is not equal to a value on the Place of Service 2 valid values table (W085781).
15	OUTPATIENT HOSPITAL CLAIM REQUIRES PROC AND REVENUE CODE	EDIT-FLG-PROC-CODE1-1	PROC-CODE(1) (Primary Procedure Code) Rejection Edit	Encounter Type Indicator is equal to 'M'; and Primary Procedure Code is equal to spaces, or Primary Procedure Code is equal to zeroes, or Primary Procedure Code is equal to '88888', or Primary Procedure Code is equal to '99999', or Primary Procedure Code is equal to '-----' (all dashes); and Revenue Code is equal to spaces, or Revenue Code is equal to '8888', or Revenue Code is equal to '9999', or Revenue Code is equal to '----' (all dashes).
16	PRIMARY PROCEDURE CODE MISSING	EDIT-FLG-PROC-CODE1-2	Rejection Edit	Procedure code is equal to spaces, or Procedure Code is equal to zeroes, or Procedure Code is equal to '88888', or Procedure Code is equal to '99999', or Procedure Code is equal to '-----' (all dashes);
17	PROCEDURE CODE NOT FOUND ON PDD FILE	EDIT-FLG-PROC-CODE1-3	Rejection Edit	Procedure Code is not found on PDD File or Procedure Code is invalid.
18	1ST SURGICAL PROCEDURE CODE INVALID	EDIT-FLG-PROC-CODE1-4	Rejection Edit	Encounter Type Indicator is equal to 'R', or Encounter Type Indicator is equal to 'M' (Surgical Outpatient); and Primary Procedure Code is not found on PDD File or Primary Procedure Code is invalid.
19	2ND SURGICAL PROCEDURE CODE INVALID	EDIT-FLG-PROC-CODE2	PROC-CODE(2) (Other ICD.9.CM Procedure Codes) Rejection Edit	Procedure Code 2 is not found on PDD file or Procedure Code 2 is invalid.

ERROR #	ERROR MESSAGE	ERROR FLAG	ACS FIELD NAME	EDIT CRITERIA
20	3RD SURGICAL PROCEDURE CODE INVALID	EDIT-FLG-PROC-CODE3	PROC-CODE(3) (Other ICD.9.CM Procedure Codes) Rejection Edit	Procedure Code 3 is not found on PDD file or Procedure Code 3 is invalid.
21	4TH SURGICAL PROCEDURE CODE INVALID	EDIT-FLG-PROC-CODE4	PROC-CODE(4) (Other ICD.9.CM Procedure Codes) Rejection Edit	Procedure Code 4 is not found on PDD file or Procedure Code 4 is invalid.
22	5TH SURGICAL PROCEDURE CODE INVALID	EDIT-FLG-PROC-CODE5	PROC-CODE(5) (Other ICD.9.CM Procedure Codes) Rejection Edit	Procedure Code 5 is not found on PDD file or Procedure Code 5 is invalid.
23	6TH SURGICAL PROCEDURE CODE INVALID	EDIT-FLG-PROC-CODE6	PROC-CODE(6) (Other ICD.9.CM Procedure Codes) Rejection Edit	Procedure Code 6 is not found on PDD file or Procedure Code 6 is invalid.
24	PROCEDURE CODE MODIFIER IS NOT VALID	EDIT-FLG-PROC-CODE-MOD	PROC-CODE-MODIFIER (Procedure Code Modifier) Rejection Edit	For Encounter Type Indicator J or M - Procedure Code Modifier is not equal to a value on the Proc Code Modifier valid values table (W040661).
25	MEDICAL DIAGNOSIS CODE MISSING	EDIT-FLG-MED-DIAG-CODE1-1	DIAG-CODE-ICD-9(1) (Principal Diagnosis Code) Rejection Edit	Encounter Type Indicator is equal to 'J'; and Service Line Diagnosis Code is equal to spaces, or Service Line Diagnosis Code is equal to zeros, or Service Line Diagnosis Code is equal to '8888888', or Service Line Diagnosis is equal to '9999999', or Service Line Diagnosis Code is equal to '-------' (all dashes).
26	MEDICAL DIAG CODE (1) NOT ON FILE	EDIT-FLG-MED-DIAG-CODE1-2	Rejection Edit	Service Line Diagnosis Code is not found on PDD file or Service Line Diagnosis Code is invalid.
27	INSTITUTIONAL DIAGNOSIS CODE MISSING	EDIT-FLG-INST-DIAG-CODE1-1	Rejection Edit	Encounter Type Indicator is equal to 'M or Encounter Type Indicator is equal to 'R'; and Principal Diagnosis Code is equal to spaces, or Principal Diagnosis Code is equal to zeros, or Principal Diagnosis Code is equal to '8888888', or Principal Diagnosis is equal to '9999999', or Principal Diagnosis Code is equal to '-------' (all dashes).

ERROR #	ERROR MESSAGE	ERROR FLAG	ACS FIELD NAME	EDIT CRITERIA
28	INSTITUTIONAL DIAG CODE (1) NOT ON FILE	EDIT-FLG-INST-DIAG-CODE1-2	Rejection Edit	Principal Diagnosis Code is not found on PDD file or Principal Diagnosis Code is invalid.
29	MEDICAL DIAG CODE (2) NOT ON FILE	EDIT-FLG-MED-DIAG-CODE2	DIAG-CODE-ICD-9(2) (Other Diagnosis Codes) Rejection Edit	Other Diagnosis Code is not found on PDD file or Other Diagnosis Code is invalid.
30	INSTITUTIONAL DIAG CODE (2) NOT ON FILE	EDIT-FLG-INST-DIAG-CODE2	Rejection Edit	Other Diagnosis Code is not found on PDD file or Other Diagnosis Code is invalid.
31	INSTITUTIONAL DIAG CODE (3) NOT ON FILE	EDIT-FLG-INST-DIAG-CODE3	DIAG-CODE-ICD-9(3) (Other Diagnosis Codes) Rejection Edit	Other Diagnosis Code is not found on PDD file or Other Diagnosis Code is invalid.
32	INSTITUTIONAL DIAG CODE (4) NOT ON FILE	EDIT-FLG-INST-DIAG-CODE4	DIAG-CODE-ICD-9(4) (Other Diagnosis Codes) Rejection Edit	Other Diagnosis Code is not found on PDD file or Other Diagnosis Code is invalid.
33	INSTITUTIONAL DIAG CODE (5) NOT ON FILE	EDIT-FLG-INST-DIAG-CODE5	DIAG-CODE-ICD-9(5) (Other Diagnosis Codes) Rejection Edit	Other Diagnosis Code is not found on PDD file or Other Diagnosis Code is invalid.
34	INSTITUTIONAL DIAG CODE (6) NOT ON FILE	EDIT-FLG-INST-DIAG-CODE6	DIAG-CODE-ICD-9(6) (Other Diagnosis Codes) Rejection Edit	Other Diagnosis Code is not found on PDD file or Other Diagnosis Code is invalid.
35	INSTITUTIONAL DIAG CODE (7) NOT ON FILE	EDIT-FLG-INST-DIAG-CODE7	DIAG-CODE-ICD-9(7) (Other Diagnosis Codes) Rejection Edit	Other Diagnosis Code is not found on PDD file or Other Diagnosis Code is invalid.
36	INSTITUTIONAL DIAG CODE (8) NOT ON FILE	EDIT-FLG-INST-DIAG-CODE8	DIAG-CODE-ICD-9(8) (Other Diagnosis Codes) Rejection Edit	Other Diagnosis Code is not found on PDD file or Other Diagnosis Code is invalid.
37	INSTITUTIONAL DIAG CODE (9) NOT ON FILE	EDIT-FLG-INST-DIAG-CODE9	DIAG-CODE-ICD-9(9) (Other Diagnosis Codes) Rejection Edit	Other Diagnosis Code is not found on PDD file or Other Diagnosis Code is invalid.

ERROR #	ERROR MESSAGE	ERROR FLAG	ACS FIELD NAME	EDIT CRITERIA
38	REVENUE CODE NOT FOUND ON PROV CHRGE FILE	EDIT-FLG-REV-CODE	REVENUE-CODE (Revenue Code) Rejection Edit	Encounter Code Type is equal to 'M'; and Primary Procedure code is valid; and Revenue Code is not equal to spaces, and Revenue Code is not equal to zeroes, and Revenue Code is not equal to '8888', and Revenue Code is not equal to '9999'. Encounter Code Type is equal to 'R', or Encounter Code Type is equal to 'M' and Primary Procedure Code is valid; and Revenue Code is equal to spaces, or Revenue Code is equal to zeroes, or Revenue Code is equal to '8888', or Revenue Code is equal to '9999', or Revenue Code is equal to '----' (all dashes). Revenue Code is not found on Provider Charge file or Revenue Code is invalid.
39	PHARMACY DRUG CODE INVALID	EDIT-FLG-RX-DRUG-CODE	DRUG-CODE (National Drug Code - NDC) Rejection Edit	Encounter Code Type is equal to 'D'; and Drug Code is non-numeric or Drug Code is equal to zeroes.
40	FLAG NOT USED			
41	UNIT OF SERVICE IS EQUAL TO ZEROES OR IS INVALID	EDIT-FLG-UNITS-SVC	UNITS-OF-SERVICE (Units of Service) Rejection Edit	Encounter Type Indicator is equal to 'J' or Encounter Type Indicator is equal to 'M' or Encounter Type Indicator is equal to 'R'; and Revenue Code is equal to 110 thru 210 or 420; and Units of Service equal zeroes. Encounter Type Indicator is equal to 'D'; and Units of Service is equal to zeroes or Units of Service is equal to 9999999. Units of Service are equal to zeroes.
42	FLAG NOT USED			
43	BABY WEIGHT NON-NUMERIC	EDIT-FLG-BABY-WEIGHT	BABY-WEIGHT (Newborn Birth Weight) Info Flag Only	Encounter Type Indicator is equal to 'R'; and Newborn Birth Weight is non-numeric.
44	PRESCRIPTION NUMBER MISSING OR INVALID	EDIT-FLG-PRESCRIP-NBR	PRESCRIPTION-NUMBER (Prescription Number) Info Flag Only	Encounter Type Indicator is equal to 'D' and Prescription Number is equal to spaces.
45	FLAG NOT USED			
46	FLAG NOT USED			

ERROR #	ERROR MESSAGE	ERROR FLAG	ACS FIELD NAME	EDIT CRITERIA
47	RECIPIENT NOT ELIGIBLE FOR DATES OF SERVICE	EDIT-FLG-NOT-ELIG-DOS	FIRST-DATE-OF-SVC RECIP-ELIG-BEG-DATE RECIP-ELIG-END-DATE Info Flag Only	Encounter First Date of Service does not fall within Eligibility Dates on the Recipient Master File.
48	PROVIDER NOT ACTIVE FOR DATE OF SERVICE (SUMMARY ONLY)	EDIT-FLG-PERF-NOT-ACT	FIRST-DATE-OF-SVC PROV-ENROL-STAT-DATE (1) (Provider Status from Provider File) Info Flag Only	Performing Provider must be active in Medicaid and eligible as of the Encounter First Date of Service.
49	INVALID RECIPIENT AGE FOR DIAGNOSIS	EDIT-FLG-AGE-DIAG	RECIP-AGE - (calculated) MINIMUM-AGE MAXIMUM-AGE (Minimum & Maximum age from Diagnosis Record) Rejection Edit	Recipient Age is not within the Recipient Age constraints on the Diagnosis Master Record.
50	INVALID RECIPIENT SEX FOR DIAGNOSIS	EDIT-FLG-SEX-DIAG	RECIP-SEX-CODE (Recipient Sex Code from Recipient File) VALID-SEX-INDIC (Valid Sex Indicator from Diagnosis Record) Rejection Edit	Recipient Sex Code on the Recipient Eligibility Master File is equal to zero; or Recipient Sex Code on the Recipient Eligibility Master File is not equal to spaces and Valid Sex Indicator on the Diagnosis Master Record is not equal to 'B'; and Valid Sex Indicator on the Diagnosis Master Record is not equal to 'M' and Recipient Sex Code on the Recipient Eligibility Master File is not equal to '1'; or Valid Sex Indicator on the Diagnosis Master Record is not equal to 'F' and Recipient Sex Code on the Recipient Eligibility Master File is not equal to '2'.
51	INVALID RECIPIENT AGE FOR PROCEDURE	EDIT-FLG-AGE-PROC	RECIP-AGE - (calculated) MINIMUM-AGE MAXIMUM-AGE (Minimum & Maximum age from Procedure Record) Rejection Edit	Recipient Age is not within the Recipient Age constraints on the Procedure Master Record.

ERROR #	ERROR MESSAGE	ERROR FLAG	ACS FIELD NAME	EDIT CRITERIA
52	INVALID RECIPIENT SEX FOR PROCEDURE	EDIT-FLG-SEX-PROC	RECIP-SEX-CODE (Recipient Sex Code from Recipient File) VALID-SEX-INDIC (Valid Sex Indicator from Procedure Record) Rejection Edit	Recipient Sex Code on the Recipient Eligibility Master File is equal to zero; or Recipient Sex Code on the Recipient Eligibility Master File is not equal to spaces and Valid Sex Indicator on the Procedure Master Record is not equal to 'B'; and Valid Sex Indicator on the Procedure Master Record is not equal to 'M' and Recipient Sex Code on the Recipient Eligibility Master File is not equal to '1'; or Valid Sex Indicator on the Procedure Master Record is not equal to 'F' and Recipient Sex Code on the Recipient Eligibility Master File is not equal to '2'.
53	INVALID PLACE OF SERVICE FOR PROCEDURE	EDIT-FLG-PLACE-PROC	PLACE-OF-SERVICE (Place of Service from the Encounter Record) I-E-PLACE-OF-SVC-IND PLACE-OF-SERVICE (Place of Service Indicator and Place of Service from Procedure Record) Rejection Edit	The Inclusive/Exclusive Place of Service Indicator for the Procedure Code is equal to 'E' (Exclusive) and the Place of Service for the Procedure Code is equal to the Encounter Place of Service.
54	PATIENT CONTROL NUMBER INVALID	EDIT-FLG-PATIENT-ACCT-NBR	PATIENT-ACCT-NUM (Hospital Patient Control Number - PCN) Info Flag	Encounter Type Indicator is equal to ‘R’; and PCN is equal to spaces, or PCN is equal to '88888888888888888888' or PCN is equal to '99999999999999999999' or PCN is equal to ‘----------' (all dashes).
55	RX DAYS SUPPLIED EXCEEDS 180, DATA ENTRY ERROR	EDIT-FLG-DAYS-SUPPL-1	DAYS-SUPPLIED (Prescription Days & Supply Rejection Edit	Days Supplied greater than 180.
56	DAYS SUPPLIED MISSING FOR DRUG ENCOUNTER	EDIT-FLG-DAYS-SUPPL-2		Days Supplied is equal to spaces, or Days Supplied is equal to zeroes, or Days Supplied is equal to '888', or Days Supplied is equal to '999'.
57	NON-NEWBORN MCO BIRTHDATE CORRECTED W/ELIG	EDIT-FLG-DOB-ELIG	RECIP-DATE-OF-BIRTH (Encounter Date of Birth & Date of Birth from Recipient File) Info Flag Only	Date of Birth is greater than zeroes, and Date of Birth is non-Newborn, and Date of Birth from the Recipient Eligibility Master file is not equal to Date of Birth from the Encounter File.

ENCOUNTER RESULTS TRANSACTION RECORD

The following information is the Record Layout for the downloadable electronic layout/structure of the Encounter Results Transaction Report for use with the MCO's copy of the X12N 837 data submissions.

```
000010*
000020*****************************************************************************
000030
000040*
000050*      ENCOUNTER RESULTS TRANSACTION RECORD
000060*
000070*   THIS RESULTS FILE WILL BE RETURNED TO THE MCOS (SIX OR SEVEN
000080*   MCOS) INDICATING ANY ERRORS AND CONTAINS SUFFICIENT
000090*   INFORMATION FOR THE MCOS TO RE-SUBMIT THE CORRECTED ENCOUNTER
000100*   CLAIMS.  THE RESULTS FILE REPLACES MMIS EXCEPTION REPORTING.
000110
000120*****************************************************************************
000130*
000140    05  P1683041-PATIENT-ACCT-NUMBER
000150                                          PIC X(38).
000160    05  P1683011-MEDICAL-RECORD-NUM
000170                                           PIC X(30).
000180    05  P1683091-TRANS-CONTROL-NUM.
000190      10  P1683022-CLM-INPUT-MEDIUM-IND
000200                                          PIC 9(1).
000210      10  P1683022-BATCH-DATE
000220                                          PIC 9(5).
000230      10  P1683022-MICROFILM-MACHINE-NO
000240                                          PIC 9(1).
000250      10  P1683022-MICROFILM-ROLL-NO
000260                                          PIC 9(1).
000270      10  P1683022-BATCH-NUMBER
000280                                          PIC 9(3).
000290      10  P1683022-DOCUMENT-NUMBER
000300                                          PIC 9(4).
000310      10  P1683022-LINE-NUMBER
000320                                          PIC 9(2).
000330    05  P1683091-ERT-FLAGS
000340              OCCURS 0250 TIMES
000350              INDEXED BY PX1683091-ERT-FLAGS.
000360      10  P1683042-LINE-ITEM-CODE
000370                                          PIC 9(3).
000380      10  P1683012-FLAG
000390                                          PIC X(01).
```

1BWMN0600-R001 WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES PAGE 1
AS OF 07/31/07 MEDICAID MANAGEMENT INFORMATION SYSTEMS RUN DATE 07/31/07
0 ENCOUNTER ERROR SUMMARY REPORT
0PLAN: 00080xxxxx

0	ERROR	ACTION	DESCRIPTION	ERROR COUNT
0	4	REJECT	RECIPIENT NOT ON FILE	49
0	6	FLAG ONLY	PAY-TO PROVIDER ID INVALID OR MISSING	410
0	8	FLAG ONLY	RENDERING/ATTENDING PROVIDER ID INVALID OR MISSING	3,034
0	17	REJECT	PROCEDURE CODE NOT ON FILE	15
0	38	REJECT	REV CODE NOT ON PROV CHARGE FILE	1
0	47	FLAG ONLY	RECIP NOT ELIG FOR DATE OF SERVICE	1,227
0	48	FLAG ONLY	PROV NOT ACTIVE FOR DATE OF SVC	1
0	49	FLAG ONLY	RECIPIENT AGE INVALID FOR DIAG	53
0	50	FLAG ONLY	RECIPIENT SEX INVALID FOR DIAG	58
0	51	FLAG ONLY	RECIPIENT AGE INVALID FOR PROC	2,763
0	52	FLAG ONLY	RECIPIENT SEX INVALID FOR PROC	26
0	53	REJECT	PLACE OF SERVICE INVALID FOR PROC	340

-TOTAL COUNT FOR PLAN ID 00080xxxxx 282,558
-TOTAL ERT RECORDS READ: 282,558
- *** END OF REPORT ***
0
1SUMMARY R001 WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES PAGE 1
AS OF 07/31/07 MEDICAID MANAGEMENT INFORMATION SYSTEMS RUN DATE 07/31/07

- U N D U P L I C A T E D R E C O R D S P R O C E S S E D

0	SUBMITTER ID	PERCENT	PROF	INST	DRUG
0	80xxxxx	100	239461	43097	0

- D U P L I C A T E R E C O R D S D R O P P E D

0	SUBMITTER ID	PERCENT	PROF	INST	DRUG
0	80xxxxx	100	15003	0	0

- *** END OF REPORT ***

1BWMN0600-R001 WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES PAGE 1
AS OF 06/30/06 MEDICAID MANAGEMENT INFORMATION SYSTEMS RUN DATE 07/31/07
0 ENCOUNTER ERROR SUMMARY REPORT
0PLAN: 00080XXXXX

	ERROR	ACTION	DESCRIPTION	ERROR COUNT
0	2	REJECT	RECIPIENT ID IS SPACES	60
0	4	REJECT	RECIPIENT NOT ON FILE	19
0	47	FLAG ONLY	RECIP NOT ELIG FOR DATE OF SERVICE	1,540
0	57	FLAG ONLY	NON-NEWBORN BIRTHDATE CORRECTED	6,309

-TOTAL COUNT FOR PLAN ID 00080XXXXX 245,939
-TOTAL ERT RECORDS READ: 245,939
- *** END OF REPORT ***
0

1BWMX500E-R001 WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES PAGE 1
AS OF 06/28/06 MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE 07/31/07
0 P O I N T O F S A L E E N C O U N T E R C L A I M S S U M M A R Y
-SUBMITTER 80XXXXX

	-- REGULAR CLAIMS ---	-- CREDIT REQUESTS --	--- DROPPED CLAIMS --	---- TOTAL CLAIMS ----	--- TOTAL CHARGES ---
-	245,939	1,040	0	246,979	$10,385,369.12

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- ***** END OF REPORT *****

March 30, 2007

Peggy Wilson, Office Chief
Department of Social and Health Services
Division of Program Support
PO Box 45530
Olympia, WA 98504-5530

RE: Encounter Data Transaction Uploads – Quarter 4, 2006

Dear Ms. Wilson:

Pursuant to 42 CFR 438.606 and to the best of my knowledge, information and belief, this letter serves as the required certification attesting to the accuracy, completeness, and truthfulness of (MCO's name) Quarter 4, 2006 Encounter Data Transactions submitted to ACS EDI-Gateway on: (list dates, file names and number of encounters/ in each file)

Sincerely,

Signature
MCO – CEO/CFO
Title